United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

Dates of Onsite Review: June 3 –7, 2013

Date of Report: August 9, 2013

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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 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 offsite 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 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, supported the work of the monitoring team, was available and responsive to all questions and concerns, and set the overall tone for the week, which was to learn as much as possible about what was required by the Settlement Agreement. The Settlement Agreement Coordinator, Etta Jenkins, again did an outstanding job, ensuring that the monitoring team was able to conduct its activities as needed.

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, including frequent questions about what it would take to come into substantial compliance. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist MSSLC in doing so.

Third, 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.

<u>Restraint</u>

- MSSLC made good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. The facility needs to focus on documenting medical restraints in compliance with the state policy and developing individualized ISPs that focus on meaningful engagement.
- There were 284 physical restraints used for crisis intervention involving 64 individuals between 10/1/12 and 3/31/13. This was about the same as the 282 physical restraints used for crisis intervention the previous six month period. Additionally, there had been nine chemical restraints used for crisis intervention from 10/1/12 through 3/31/13.

- The facility reported 20 instances of dental/medical restraint sedation from 10/1/12 through 3/31/13 including three instances of pretreatment sedation involving two individuals and 17 medical mechanical restraints including binders, helmets, and mittens.
- Action taken by the facility to address compliance with section C since the last monitoring visit included:
    - Implementation of the new statewide restraint forms.
    - Consultation with the Hogg Foundation consultant to develop restraint reduction strategies for individuals identified by the Restraint Reduction Committee.
    - Development of an Active Treatment Committee.
    - Development of medical restraint action plans for six individuals.

Abuse, Neglect, and Incident Management

- There were six confirmed cases of physical abuse and five confirmed cases of neglect. DFPS conducted investigations involving 485 allegations at the facility between 9/1/12 and 4/30/12, including 340 allegations of physical abuse, seven allegations of exploitation, and 140 allegations of neglect. An additional 328 other serious incidents were investigated by the facility.
- There were 1011 injuries reported between 9/1/12 and 2/28/13. These included 22 serious injuries resulting in fractures or sutures.
- Minimal progress had been made in adequately following up on incidents by addressing factors contributing to the large number of incidents and injuries at the facility. The facility will need to make appropriate recommendations with a focus on systemic issues that were identified through trend analysis.

Quality Assurance

- The QA program at MSSLC made progress. Many of the components of a QA program were initiated. The QA data list inventory and the QA plan narrative were improved since the last review. The QA plan matrix was almost identical to what was submitted for the previous two monitoring reviews and needed much improvement.
- Progress was seen regarding the gathering and organization of data. Data from all 20 sections of the Settlement Agreement were summarized and graphed showing trends over time. The length of time (i.e., number of months), breadth of topics covered, and quality of the summation of the data, however, varied greatly across these 20 sections and across the past six months.
- Of the 20 sections of the Settlement Agreement, 10 (50%) appeared in a QA report at least once in each quarter. An area for improvement was for the section leaders to do more of an analysis of their data.
- The QAQI Council met at least once each month. Minutes indicated that the agenda included relevant and appropriate topics. An adequate written description did not exist that indicated how CAPs were generated, including the criteria for the development of a CAP. There were five CAPs; all five were regarding nursing services.

Integrated Protections, Services, Treatment, and Support

- There was positive progress evident with the new ISP process. At three ISP meetings and two pre-ISP meetings observed by the monitoring team, progress had been made towards integrating the risk identification process into the ISP process. Rather than being two separate discussions held within the same meeting, the risk discussion was to some degree woven into the discussion regarding the individual's preferences, daily schedule, and support needs. Each IDT was in a different stage of integration, but all were moving in a positive direction. To move forward,
    - Assessments must be completed at least 10 days prior to the annual IDT meeting and available to all team members for review.
    - IDTs need to ensure that deadlines are set and responsibility assigned when additional assessments are recommended by the team.
    - All team members need to ensure that supports are monitored for consistent implementation and adequacy. Data collected during monitoring should be used to revise supports when there is regression or lack of progress.
- The new process, thus far however, was not resulting in adequate supports and measurable outcomes in many cases.

Integrated Clinical Services

- There was no significant progress noted in this area. MSSLC had not implemented any facility initiative that was intended to specifically foster integration among the clinical disciplines. Nonetheless, the monitoring team did find integration occurring in several areas, however, there were many opportunities to improve integration of clinical services that were being missed.
- The policy related to the minimum common elements of clinical care was submitted to QAQI Council for approval. This policy did not adequately address Provision G. The monitoring team had the opportunity to meet with the medical director to discuss integration activities at the facility. This discussion focused on some of the activities that were occurring as well as the next steps that should be taken to move towards substantial compliance.

Minimum Common Elements of Clinical Care

- The facility made very little progress in this area. A policy for the minimum common elements of clinical care was submitted to the QAQI Council for approval the week of the compliance review.
- MSSLC was tracking assessments, but this was limited to timelines only. There was no documentation provided relative to the quality of the assessments.
- There was no additional work done in the development of clinical indicators, but the proposed policy provided guidance on indicator selection and management. Much of this provision revolves around issues of quality and assessment of the quality of clinical care provided. As such, the development of a robust set of clinical indicators must be a priority in moving forward.

At-Risk Individuals

- Progress had been made on meeting substantial compliance through an initial attempt to ensure individuals were accurately assessed and action plans were in place to address risks. New statewide risk assessment procedures, with guidelines for rating risk, was in use at the facility. Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred since the last review.
- Risk screening was reviewed annually at the ISP planning meeting. There was still a tendency to over-rely on the guidelines for each risk category without factoring in how the various risk factors may compound one another.
- The monitoring team had a chance to observe two teams hold meetings utilizing the new format. Progress had been made towards integrating the risk discussion in relation to each individual's preferences, strengths, and daily schedule. The facility was moving in a positive direction, though additional training was still needed to help team develop meaningful plans through this process.
- 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 reviewing supports following a change in status, but failing to ensure that assessments were completed and recommendations were implemented.

Psychiatric Care and Services

- MSSLC met substantial compliance for five sections of provision. The department had a full time lead psychiatrist and three other full time equivalent board certified psychiatrists. The facility also acquired consultation from a child and adolescent psychiatrist in the community for youth at MSSLC.
- There was improved integration. Psychology and psychiatry conducted a routine meeting together inclusive of the director of psychology, lead psychiatrist, medical director, and other staff from both departments.
- The completion of psychiatric assessments, both quarterly and Appendix B comprehensive evaluations, had progressed to 95%. Many individuals who were prescribed numerous medications continued to receive most of their medications in fear of an exacerbation of behavioral challenges. The IDT did not resort to the utilization of non-pharmacological interventions in these scenarios and requested continued medication by the psychiatrist.
- The facility needs to be cognizant of all the offsite pretreatment sedation procedures, details, and the potential effects of the medication administered to the individual, even if received at another facility.
- The facility administered a Reiss screen for 100% of the new admissions to the facility and to everyone else at MSSLC. A database was used to track the administration dates and scores of the MOSES and DISCUS. The manner in which the data were presented made it difficult to follow the completion of the instruments over the course of time because data were not sequential.

- There were onsite neuropsychiatric clinics that took place at MSSLC since last review. The neurologist had recently begun working through the IDT process to identify indications and target symptoms for the AED regimen.

Psychological Care and Services

- Improvements since the last onsite review included the numbers of psychologists with certification as applied behavior analysts, and development of a project to ensure that all data are recorded in a timely fashion, data are reliable, and PBSPs are implemented as written. There was also an increase in the number of new functional assessments, the comprehensiveness of the functional assessments, the number of individuals with an annual psychological assessment, and the comprehensiveness of the annual psychological assessments. There was improvement in the quality of PBSPs and in the DCPs' reports that they understood PBSPs.
- The facility should reinitiate the collection of interobserver agreement, increase the flexibility of the system for collecting both target and replacement data, establish minimal frequencies of data collection reliability and IOA collection, and demonstrate that those frequencies of data collection are achieved. In addition, the facility should ensure that all individuals with PBSPs have monthly progress notes, increase the percentage of current functional assessments completed for individuals with PBSPs, increase the percentage of individuals with annual psychological assessments, and ensure that all PBSPs are based on the hypothesized function of the target behavior.

Medical Care

- The new medical director had been in his position for six months. He was aware of the numerous challenges that faced the department, including the significant concern of medical staff turnover. He maintained a caseload, so this decreased the overall time that could be devoted to management issues. Nonetheless, it was apparent that several long term problems were beginning to show improvement.
- Basic health care services were provided to the individuals at MSSLC. The routine screening exams and vaccinations were provided with high rates of compliance. Overall, documentation in the records had improved. Annual Medical Assessments were completed in a timely manner. The documentation of consultations was also much improved.
- Follow-up of medical issues was a concern, particularly following hospitalization. Several individuals had recurrent pneumonia and were reviewed by the Pneumonia Review Committee.
- The facility had not addressed the development of a medical quality program and was not tracking data related to this. There was evidence that steps were taken to improve quality and compliance with the various guidelines and protocols.

Nursing Care

- The facility made progress in all provisions. RN Case Management was fully staffed with 28 RN case managers, however, the facility was heavily reliant upon agency nurses. There was improvement in the establishment of a

centralized person within case management to provide one-on-one training, mentoring, and shoulder to shoulder interface.

- The Infection Control Program continued to make improvement in surveillance activities of tracking and trending infections, and the implementation of training.
- The RN case manager was working towards gathering accurate data in the completion of nursing assessments. Improvement included the development of prompts within the nursing assessment tool and support of the nursing case managers with one-on-one review competency review of completed nursing assessments.
- A process to accurately identify risk and to develop an integrated health care plan, by the relevant disciplines, was still needed. The newly implemented Integrated Risk Rating Form and Integrated Health Care Plan, and their associated processes were too implemented too recently to demonstrate substantial compliance.
- Provision M6 remained in substantial compliance.

Pharmacy Services and Safe Medication Practices

- The momentum seen in the last compliance review was dampened by multiple staffing changes. The pharmacy director remained very steadfast in her efforts to improve medication practices at the facility. Her presence and contributions to the department and the facility were visible throughout the week of the review. It appeared that the pharmacy department worked collaboratively with other clinical areas, such as medical, nursing, and habilitation services.
- The documentation of communication between the pharmacists and prescribers improved. The facility did not execute the WORx program in accordance with state guidelines largely because the decision was made to override the alerts. The practice of overriding alerts occurred from June 2012 to March 2013.
- The QDRR process showed a substantial decline with regards to timelines and, to some extent, the quality of the reviews diminished as well. The facility continued to have difficultly completing the MOSES and DISCUS evaluations.
- Overall, the number of ADRs reported increased. Nonetheless, there continued to be a disconnect between the ADR system and the greater system of monitoring for psychopharmacologic side effects. Drug utilization evaluations were completed as required and provided good information for facility staff. Corrective actions were implemented and the facility will need to monitor the effectiveness of the corrective actions.
- The monitoring team saw no progress in the medication variance system. Problems were noted in all five components of the Medication Use System.

Physical and Nutritional Management

- Progress was made towards substantial compliance with provision O. The PNMT was fully staffed, a number of overdue comprehensive assessments had been completed, and these were much improved. The meeting observed by the monitoring team was organized and the documentation greatly improved. Team members concisely and efficiently presented data for analysis and review relative to individual status.

- Mealtimes and position and alignment were improved, though some issues in positioning and transfers continued to be an issue.
- A system of effectiveness monitoring was not well established and will be necessary for further progress.
- The therapists were encouraged to more objectively evaluate individuals for protective equipment. There were a large number of helmets, gait belts, staff assistance, protective boots, for example.

Physical and Occupational Therapy

- There was a decline in the status of substantial compliance in several aspects of provision P. The majority of the assessments, though completed, were completed after the ISP.
- The content of assessments reflected regression in approximately 33% of these. While there were improvements related to 43% of the elements, only 6% of the assessments reviewed contained over 60% of the required elements. The average for all 16 assessments was approximately 44%.

Dental Services

- Progress was seen in the provision of dental services. The facility continued to provide basic dental services onsite, while more advanced services were provided at a local hospital. Many individuals continued to have 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 declined. New initiatives were implemented to help improve this problem.
- Comprehensive dental assessments were required every six months. Most, but not all, met this timeline. Maintaining this compliance rate was a significant achievement. Additionally, the quality of the assessments improved as well.
- Failed appointments decreased to 15%. The dental clinic had implemented a procedure prior to the last visit designed to increase accountability with getting individuals to clinic on time.
- It was reported that more individuals were requesting treatment at Scott and White. Consult notes indicated that individuals were requesting to be put to sleep for dental work. The dental director needs to assess the timelines to ensure that sending an increased number of individuals out for treatment does not result in delays in treatment.

Communication

- There was a decline in status towards substantial compliance in several aspects of provision R, however, the new department director was already making many needed changes.
- The majority of the assessments, though completed, were completed after the ISP. The content of assessments reflected that most of the key elements were contained in less than 50% of assessments reviewed. There was no increase in the provision of AAC systems. Therapists should be observing the position and set up of activities in these areas to improve alignment and support, increase productivity and promote new skill acquisition.

- More clinical knowledge related to the application of AAC to adults with developmental disabilities and physical and cognitive challenges was needed. The clinicians did not appear to have significant experience in the provision of AAC.

Habilitation, Training, Education, and Skill Acquisition Programs

- Improvements since the last review included modification of the SAP format, initiation of a monthly Skill Acquisition Review Committee (SARC) meeting, and improvements in the percentage of SAPs reviewed with clear plans of generalization and maintenance. There were also improvements in the documentation of how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans. SAP implementation also improved.
- The facility should identify target levels of SAP integrity and skill training in the community, and ensure the achievement of those levels.

Most Integrated Setting Practices

- MSSLC made progress across much of section T. The number of individuals placed was at an annual rate of about 16%. Approximately 16% of the individuals at the facility were on the active referral list.
- 33 individuals had been placed in the community since the last onsite review. 52 individuals were on the active referral list. 2 individuals were returned to the facility after community placement. Of the 60 individuals who moved in the past 12 months, 8 were reported to have one or more untoward events (13%).
- Delays in transfer/activation of SSA and Medicaid benefits, however, delayed the implementation and/or receipt of some services for some individuals once they moved to the community.
- Transitions were not occurring at a reasonable pace. Of the 52 individuals on the active referral list for community transition, 28 had exceeded the 180-day timeframe.
- Improvement was needed in having the discharge assessments indicate how supports might be implemented in the new settings. The list of CLDP pre- and post-move supports continued to need much improvement. Many of the important categories and aspects of a comprehensive list of supports were not included in almost all of the CLDPs.
- Post move monitoring continued to be provided on time, thoroughly, and across the state. Two post move monitorings were completed using the new iteration of the report form. The monitoring team listed a number of concerns regarding this.

Guardianship and Consent

- The facility had not yet developed an adequate assessment process for determining the need for guardianship. IDTs were in the beginning stages of holding adequate discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent.

- The facility had not developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continued to need training to determine each individual's functional capacity to render informed decisions.
- A priority list of those in need of a guardian had been developed, and the facility was moving forward with procuring guardianship for individuals with a prioritized need.

Recordkeeping Practices

- Continued progress was seen in all aspects of provision V, including substantial compliance with section V1. The active records continued to improve in areas including legibility and number of missing documents. Individual notebooks continued to be used for all individuals. 100% of the individual notebooks reviewed by the monitoring team contained the current ISP, IRRF, and IHCP.
- Not all state policies were in place yet, though continued progress was evident (only provisions G, H, and S did not have a state policy). MSSLC now had two very good spreadsheets to address this provision.
- Five reviews (audits) were conducted in each of the previous six months. All audits were done by the one URC. An occasional inter-observer agreement should be conducted. A half-page description of how the recordkeeping department addressed V4 was given to the monitoring team. This was a good, though small, first step.

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 Restraint Trend Analysis Reports for the past two quarters
o Sample of IMRT Minutes from the past six months
o List of all restraint by Individual in the past six months
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 crisis intervention plans
o List of individuals with desensitization plans
o Desensitization plans for Individual #1, Individual #492, Individual #500, Individual #49, Individual #372, Individual #196, Individual #484, and Individual #456.
o Restraint Reduction Committee meeting minutes for past six months
o Special Restraint Review Tracking Log
o Sample #C.2, training transcripts for 24 MSSLC employees
o Sample #C.3, documentation for protective mechanical restraint and ISP for:
• Individual #196, Individual #293, Individual #143, Individual #266, Individual #303, Individual #511, Individual #188, Individual #285, Individual 61, and Individual #395.
o ISPs, PBSPs, Crisis Intervention Plans (when applicable), and ISPAs for:
• Individual #56, Individual #466, Individual #483, Individual #15, Individual #356, Individual #556, Individual #492, and Individual #98, Individual #715, Individual #398, Individual #508
o A sample (#C.1) of restraint documentation for crisis intervention including:
<table>
<tr><th>Individual</th><th>Date</th><th>Type</th></tr>
<tr><td>#56</td><td>3/18/13@3:30 pm</td><td>Physical</td></tr>
<tr><td>#56</td><td>3/4/13@2:49 pm</td><td>Physical</td></tr>
<tr><td>#56</td><td>2/22/13@7:17 pm</td><td>Physical</td></tr>
<tr><td>#56</td><td>2/27/13@ 2:07 pm</td><td>Physical</td></tr>
<tr><td>#56</td><td>2/25/13@2:50 pm</td><td>Physical</td></tr>
</table>
</td></tr>
</table>

#56	2/20/13 @ 8:06 am	Physical
#56	2/15/13 @ 3:20 pm	Physical
#56	1/31/13 @ 1:57 pm	Physical
#56	1/30/13 @ 5:10 pm	Physical
#56	1/23/13 @ 6:55 pm	Physical
#466	3/19/13 @ 4:05 pm	Physical
#466	3/12/13 @ 11:03 am	Physical
#466	3/7/13 @ 5:27 am	Physical
#466	2/22/13 @ 10:00 pm	Physical
#466	2/22/13 @ 10:29 pm	Physical
#466	2/22/13 @ 11:05 pm	Physical
#466	2/22/13 @ 11:10 pm	Chemical
#483	1/28/13 @ 10:33 am	Physical
#483	1/11/13 @ 2:25 pm	Physical
#483	1/5/13 @ 7:10 pm	Physical
#483	1/5/13 @ 6:54 pm	Physical
#483	12/25/12 @ 3:41 pm	Physical
#483	12/25/12 @ 11:40 am	Physical
#483	12/21/12 @ 5:19 pm	Physical
#15	3/28/13 @ 5:42 pm	Physical
#356	3/30/13 @ 5:55 pm	Physical
#556	3/30/13 @ 11:11 pm	Physical
#492	3/15/13 @ 4:23 pm	Chemical
#492	3/24/13 @ 8:52 am	Chemical
#98	2/25/13 @ 1:20 am	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
- Kim Williams, QDDP Director
- Joy Lovelace, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 6/3/13 and 6/5/13
- ISP preparation meeting for Individual #589
- Annual IDT Meeting for Individual #278 and Individual #398
- Longhorn Unit Meeting 6/4/13

Facility Self-Assessment:

MSSLC submitted its self-assessment. The self-assessment was updated on 5/17/13. 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 reviewed all crisis intervention restraints from 10/1/12 through 3/31/13 (284) to assess compliance with each provision. Additional activities similar to those engaged in by the monitoring team were completed along with the review of restraint documentation. For instance, to assess compliance with C1, the facility also reviewed the facility policy and restraint training curricula, ISPs for individuals who were the subject of medical restraints, video reviews of restraints, and restraint data. The facility self-assessment commented on the overall compliance rating for each provision item based on assessment findings.

The facility assigned a self-rating of substantial compliance to C1, C2, and C3. C4, C5, C6, C7, and C8 were self-rated as noncompliant. The monitoring team found compliance with C2, C3, and C4. A variance in rating was partially due to the monitoring team addressing the lack of medical restraint plans in C1, while the facility addressed this concern in C4. The monitoring team, however, also found that there was not sufficient evidence available to support that restraints were not occurring due to a lack of adequate supports and treatment.

Summary of Monitor's Assessment:

Based on information provided by the facility, there were 284 physical restraints used for crisis intervention involving 64 individuals between 10/1/12 and 3/31/13. This was about the same as the 282 physical restraints used for crisis intervention the previous six month period. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting compliance with the requirements of section C.

Month	Total Restraints	Month	Total Restraints
April 2012	45	October 2012	61
May 2012	55	November 2012	40
June 2012	30	December 2012	53
July 2012	44	January 2013	36
August 2012	42	February 2013	39
September 2012	66	March 2013	55

Additionally, there had been nine chemical restraints used for crisis intervention from 10/1/12 through 3/31/13.

	The facility reported 20 instances of dental/medical restraint from 10/1/12 through 3/31/13 including : • Three instances of pretreatment sedation involving two individuals. • 17 medical mechanical restraints including binders, helmets, and mittens. Action taken by the facility to address compliance with section C since the last monitoring visit included: • Implementation of the new statewide restraint forms. • Consultation with the Hogg Foundation consultant to develop restraint reduction strategies for individuals identified by the Restraint Reduction Committee. • Development of an Active Treatment Committee. • Development of medical restraint action plans for six individuals. Overall, the facility made good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. The facility needs to focus on documenting medical restraints in compliance with the state policy and developing individualized ISPs that focus on meaningful engagement.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>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.</td><td>A review of the Trend Analysis Reports for the past two quarters, showed:

<table>
<tr><th>Type of Restraint</th><th>(Oct. 2012-Mar 2013)</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>284</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>9</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>0</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>293</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>64</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>21</td></tr>
<tr><td>Medical/dental restraints</td><td>20</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>18</td></tr>
</table>

Prone Restraint
a. Based on facility policy review, prone restraint was prohibited.

b. Based on review of other documentation (trend reports and lists of restraints) prone restraint was not identified.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		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 restraints for eight individuals, representing 11% of restraint records over the last six-month period and 13% of the individuals involved in restraints. The sample included 24 physical restraints and four chemical restraints. Sample #C.1 included the three individuals with the greatest number of restraints, as well as five individuals who were some of the most recent application of restraints. c. Based on a review of the restraint records for individuals in Sample #C.1 involving five individuals, zero (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> e. Based on document review, the <u>facility</u> and <u>state</u> policies state 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; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • f. In 30 of the 30 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • g. For the 30 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 29 (97%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. o The restraint checklist for Individual #492 dated 3/24/13 did not describe events that led to the behavior. • h. In 28 of the records (93%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. o The restraint checklist for Individual #492 dated 3/24/13 did not document staff attempts at other interventions. o The restraint review for Individual #98 dated 2/25/13 noted that the psychologist recommended early administration of his medication rather than the chemical restraint that was administered.	

#	Provision	Assessment of Status	Compliance
		• i. Facility policies identified a list of approved restraints. • j. Based on the review of 30 restraints, involving eight individuals, 30 (100%) were approved restraints. k. In 19 of these records (63%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. The restraint review for Individual #492 dated 3/15/13 indicated that the quality medical review team recommended a patient specific active treatment plan and behavioral consult. It was not evident that an individualized active treatment plan was in place at the time of the restraint incident. Ten restraints reviewed for Individual #56 were preceded by an altercation with peers when "sitting" in the common area of the home. Six (60%) of those occurred on weekday afternoons between 2:00 pm and 3:30 pm when day programming should have been occurring. Restraint documentation indicated that he was not engaged in programming or treatment at the time of the restraints. His last structural and functional assessment was completed on 1/30/10. It indicated that he "likes any activity that has him up and doing things." Activities that he reportedly enjoys included canteen, gym, off campus trips, movies, eating out, household chores, and shopping. Recommendations from the functional assessment included: • Limited home restriction; • Referral to an alternative work environment; • Efforts to make the vocational setting more socially reinforcing; and • Access to a relaxation room. None of the recommendations were addressed in his ISP. There was no indication that an adequate vocational assessment had been completed to assess his work preferences and his ISP did not include an individualized active treatment schedule that included engagement in meaningful activities. During the week of the monitoring visit, staff consistently reported that there had been a significant increase in behavioral incidents related to frequent moves of individuals between homes in the past nine months. Staff reported that individuals often moved without sufficient transition supports, including staff training on the individual's preferences and support needs. Some individuals at the facility reported that they were not sufficiently involved in the decision making process prior to moving.	

#	Provision	Assessment of Status	Compliance
		The facility had established a desensitization committee to review appointment refusals and the use of chemical pretreatment sedation prior to medical and dental appointments. The committee made recommendations to the IDT when individuals showed a pattern of refusals to attend medical or dental appointments. According to a list provided by the facility, two individuals had required the use of pretreatment sedation prior to medical appointments. The facility reported that there were no protective mechanical restraints in use to prevent self-injurious behavior. l. The facility had identified17 individuals using medical mechanical restraints. This included binders, mittens, and helmets. Medical restraint plans had been developed for six (35%) of the individuals identified to provide staff with instructions for monitoring the restraint. The facility made very good progress towards compliance with C1. Restraint plans had not yet been developed for all individuals who were wearing protective mechanical restraints classified as medical restraints by the facility. Plans will need to be developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation. ISPs that include a focus on engagement in individualized activities based on preferences and support needs should be developed for each individual.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the eight individuals in Sample #C.1 were reviewed. Of these, five of the individuals had Crisis Intervention Plans that defined the use of restraint. a. For the four individuals involved in physical restraint who had Crisis Intervention Plans, 18 of 18 (100%) restraint checklists included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. b. For two individuals who did not have Crisis Intervention Plans, two (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Based on this review, the facility is in compliance with C2.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample #C.2 was randomly selected from a current list of staff. b. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: • 24 of the 24 (100%) had current training in RES0105 Restraint Prevention and Rules. • 16 of the 18 (89%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training. 24 of the 24 (100%) had completed PMAB training within the past 12 months. • 18 of the 18 (100%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. c. Based on responses to questions, six direct support professionals answered the following questions correctly: • What policies govern the use of restraint? (100%); • Describe two verbal or redirection techniques (100%); • Describe two approved restraint techniques. (100%); and • How would you supervise an individual in restraint? (100%). d. In 28 of the records (93%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. • The restraint checklist for Individual #492 dated 3/24/13 did not document staff attempts at other interventions. • The restraint review for Individual #98 dated 2/25/13 noted that the psychologist recommended early administration of the individual's medication rather than the chemical restraint that was administered.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on this review, the facility was in substantial compliance with training requirements.	
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.	a. Based on a review of 30 restraint records (Sample #C.1), in 30 (100%) there was evidence that documented that restraint was used as a crisis intervention. b. In review of 11 Positive Behavior Support Plans, in 11 (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). c. In addition, facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. d. In 30 of 30 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list maintained by the facility. e. Restraints from Sample #C.1 for Individual #56, Individual #466, and Individual #483 were reviewed. In 24 of 24 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the form used by the facility to document restraint considerations/restrictions. f. In 24 of 24 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. The facility reported that medical pretreatment sedation had been used in three instances for two individuals at the facility. The use of pretreatment sedation was reviewed by the facility Desensitization Committee. The committee met to review trends of refusals for routine medical and dental appointments. Recommendations were made by the committee, as appropriate, for the development of desensitization strategies. Based on a review of desensitization plans for eight individuals, g. In eight (100%), individualized strategies to minimize or eliminate the need for restraint had been developed. Based on this review, the facility was in substantial compliance with C4.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
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.	a. Review of facility training documentation showed that there was an adequate training curricula for restraint monitors on the application and assessment of restraint. b. This training was competency-based. c. Based on review of restraint records in Sample #C.1, eight staff who performed the duties of a restraint monitor (100%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. Based on a review of 30 restraint records (Sample #C.1), a face-to-face assessment was conducted: • d. In 30 out of 30 incidents of restraint (100%) by an adequately trained staff member. • e. In 29 out of 30 instances (97%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. o The restraint monitor did not arrive until 33 minutes after the initiation of the restraint for Individual #56 dated 2/15/13. • f. In 30 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • g. In 23 instances (77%), the documentation showed that an assessment was completed of the consequences of the restraint. The following restraint checklists did not indicate that an assessment was completed for injuries to the individual: o Individual #483 on 12/25/13 and 12/21/12 o Individual #15 on 3/28/13 o Individual #356 on 3/30/13 o Individual #56 on 3/18/13 and 2/15/13 o Individual #466 on 3/19/13 Based on a review of 30 restraint records for restraints that occurred at the facility (Sample #C.1), there was documentation that a licensed health care professional: • j. Conducted monitoring at least every 30 minutes from the initiation of the restraint in 28 (93%) of the instance of restraint. o The restraint record for Individual #356 did not indicate that his vital signs were checked following the restraint. o A restraint checklist was not submitted for Individual #98 dated 2/25/12. • k. Monitored and documented vital signs in 29 (93%). • l. Monitored and documented mental status in 29 (93%).	Noncompliance

#	Provision	Assessment of Status	Compliance
		Based on documentation provided by the facility, one restraint in the sample had occurred off the grounds of the facility. A sample of one was reviewed (Individual #483 on 12/28/12). A licensed health care professional: • m. Conducted monitoring within 30 minutes of the individual's return to the facility in one out of one (100%). • n. Monitored and documented vital signs in one (100%). • o. Monitored and documented mental status in one (100%). Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. It represented 26% of the individuals for whom medical restraint was used. For these individuals, p. In five out of five (100%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and • q. In zero out of zero (N/A), the physician specified the type of monitoring required if it was different than the facility policy. • r. In five out of five of the medical restraints (100%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Based on this review, the facility was not in substantial compliance with the requirement for an assessment to review the consequences of the restraint. All individuals should be immediately assessed for injury following a restraint incident.	
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	A sample (Sample #C.1) of 30 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: • a. In 30 (100%), continuous one-to-one supervision was provided; • b. In 30 (100%), the date and time restraint was begun; • c. In 30 (100%), the location of the restraint; • d. In 29 (93%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. The exception was the restraint for Individual #492 dated 5/24/13 and Individual #98 dated 2/25/13. • e. In 29 (97%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. The exceptions were the restraint for Individual #492 dated 5/24/13. • f. In 30 (100%), the specific reasons for the use of the restraint • g. In 30 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint;	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• h. In 30 (100%), the names of staff involved in the restraint episode; • Observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In 30 (100%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration). The longest restraint in the sample was 14 minutes. • l. In 30 (100%), the level of supervision provided during the restraint episode; • m. In 30 (100%), the date and time the individual was released from restraint; and • n. In 23 (77%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. Records that did not document assessment were: o Individual #56 dated 3/18/13 and 2/15/13 o Individual #466 dated 3/19/13 o Individual #483 dated 12/25/12 and 12/21/12 o Individual #15 dated 3/28/13 o Individual #356 dated 3/30/13 o. In a sample of 30 records (Sample #C.1), restraint debriefing forms had been completed for 30 (100%). p. A sample of eight individuals subject to medical mechanical restraint was reviewed (Sample #C.3). On four (50%) of the restraint checklists, staff indicated that the individual was on enhanced supervision. The ISP for the remaining four did not include the level of supervision or indication that the physician had ordered alternate supervision while in restraint. Sample #C.4 was a subsample of the four chemical restraints included in Sample #C.1. q. In three (75%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. The Chemical Restraint: Consult and Review Form for Individual #98 indicated that the psychologist recommended early administration of routine medication in place of a chemical restraint. Based on this review, the facility was not in substantial compliance with the requirements of C6. To gain substantial compliance, • An injury assessment should be completed and the results documented on the restraint checklist immediately following each restraint incident.	

#	Provision	Assessment of Status	Compliance
		• Physician orders should be obtained for all medical restraints that include the level of supervision and frequency of monitoring. Staff should document compliance with the physician's orders. Prior to the administration of the chemical restraint, the licensed health care professional should contact the psychologist to assess whether less intrusive interventions are available and whether or not conditions for administration of a chemical restraint had been met.	
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, 17 individuals were placed in restraint more than three times in a rolling 30-day period. This represented an increase from the last review when eight individuals were placed in restraint more than three times in a rolling 30-day period. Five (i.e., Individual #483, Individual #398, Individual #508, Individual #56, and Individual #715) of these 17 individuals (29%) 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 (ISPAs) meeting minutes that occurred as a result of more than three restraints in a rolling 30-day period were requested for each individual. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. In order to achieve substantial compliance with this provision item, the minutes from 85% of the 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. Two (i.e., Individual #398 and Individual #56) of the five ISPA minutes reviewed reflected a discussion of adaptive skills, or biological, medical, or psychosocial factors affecting the behaviors provoking restraints, however, no discussion of possible action was documented in the ISPA.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(b) review possibly contributing environmental conditions;	This item was rated as being in noncompliance because only one (i.e., Individual 483's) of the five ISPA meeting minutes reviewed (20%) reflected a discussion of possible contributing environmental factors, and suggestions for modifying them to prevent the future probability of restraint. Individual 483's ISPA meeting minutes indicated that working with unfamiliar staff was an environmental condition that was associated with an increase in dangerous behavior, and recommended that only familiar staff be assigned to work with Individual #483. Individual #398's ISPA meeting minutes indicated that loud and chaotic environments may contribute to his dangerous behavior that provoked restraint, however no suggestions for modifying that environmental condition was documented.	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. This item is rated as noncompliance because none of the ISPA minutes reviewed (0%) reflected both a discussion of potential environmental antecedents, and if they were 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. Three of ISPA's reviewed reflected a discussion of potential antecedents that could potentially affect the dangerous behaviors that provoke restraint, however, none of these ISPAs documented a discussion of actions or plans to reduce these antecedents effects on this dangerous behaviors.	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. Four (Individual #56, Individual #508, Individual #398, and Individual #483) ISPAs reviewed reflected a discussion of potential variables that were hypothesized to maintain the dangerous behaviors which provoked restraint. None, however, reflected a discussion of action to address these potential sources of motivation for dangerous 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 five individuals reviewed (100%) had a PBSP to address the behaviors provoking restraint. The following was found: • All five PBSPs reviewed (100%) 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), • Four (Individual #508, Individual #483, Individual #56, and Individual #715) of the five PBSPs reviewed (80%) 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 five of the PBSP specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint • Four (Individual #508, Individual #483, Individual #56, and Individual #715) of the five PBSPs reviewed (80%) contained interventions to weaken or reduce the behaviors that provoked restraint that was based on the functional assessment results. All five of the Individuals reviewed (100%) had a crisis intervention plan. The following was found: • For all five the type of restraint authorized was delineated, • For all five the maximum duration of restraint authorized was specified, • For all five the designated approved restraint situation was specified, and • For all five 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
	(g) as necessary, assess and revise the PBSP.	Two (Individual #483 and Individual #398) of the five ISPAs reviewed (40%) documented that the PBSPs were evaluated and it was determined that no changes were necessary. There was no evidence, however, in the ISPAs reviewed that the other three PBSPs were reviewed. In order to achieve substantial compliance with this provision item, 85% 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

#	Provision	Assessment of Status	Compliance
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.	A sample of documentation related to 30 incidents of non-medical restraint was reviewed (Sample #C.1), this documentation showed that: • a. In 22 (73%), the review by the Unit IDT occurred within three business days of the restraint episode and this review is documented by signature on the Restraint Checklist and/or Debriefing Form. o Individual #56 dated 1/31/13 -late o Individual #466 dated 3/7/13 -late o Individual #466 dated 2/22/13 (x4) – not dated o Individual #483 dated 12/21/12 – late o Individual #492 dated 3/24/13 - late • b. In 19 (63%), the review by the IMRT occurred within three business days of the restraint episode and this review is documented by signature on the Restraint Checklist and/or Debriefing Form. o Individual #56 dated 2/22/13- not dated o Individual #56 dated 2/27/13 – not dated o Individual #56 dated 1/31/13 –not dated o Individual #466 dated 3/19/13 –late o Individual #466 dated 3/7/13 - late o Individual #466 dated 2/22/13 – not dated o Individual #483 dated 12/21/12 – late o Individual #483 dated 12/25/12 – not dated o Individual #492 dated 3/15/13 – late o Individual #492 dated 3/24/13 – late o Individual #98 dated 2/25/13 – not dated • c. In 30 (100%), the circumstances under which the restraint was used was determined and is documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • d. In 30 (100%), the review conducted by the restraint monitor was sufficient to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. • e. Documented referrals were not made to the team for restraint incidents in the sample. A review of documentation for Individual #56 and #483 indicated that the IDT met when there were three or more restraints in a 30 day period. • f. See C7 for comments regarding the adequacy of IDT review of restraint incidents.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility had an in-depth review process in place that could be requested by team members when problems were identified with the restraint incident. This review resulted in additional interviews with staff present and a video review of the restraint incident when available. Recommendations were made for corrective action when warranted. Based on this review, the facility was not in substantial compliance with review requirements. All restraints should be reviewed by both the unit director and IMRT within three business days of the restraint incident.	

Recommendations:

1. For all mechanical medical restraints, plans will need to be developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation (C1).

2. The facility should develop individualized transition plans prior to a change in home settings for each individual involved and for those individuals in homes effected by the transition (C1)

3. An injury assessment should be completed and the results documented on the restraint checklist immediately following each restraint incident (C5, C6).

4. Physician orders should be obtained for all medical restraints that include the level of supervision and frequency of monitoring. Staff should document compliance with the physician's orders (C6).

5. Prior to the administration of the chemical restraint, the licensed health care professional should contact the psychologist to assess whether less intrusive interventions are available and whether or not conditions for administration of a chemical restraint had been met (C6).

6. For provision C7:
    a. Ensure that ISPA meetings following more than three restraints in a rolling 30-day period reflect a discussion of:
        i. 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.
        ii. possible contributing environmental factors, and if they are hypothesized to be relevant to the behaviors that provoke restraint, suggestions for modifying them to prevent the future probability of restraint.
        iii. potential environmental antecedents, and if they were 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.

        iv. 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.

b. The PBSPs to address the behaviors provoking restraint should:
    i. specify the alternative, positive, and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that initiated the use of the restraint
    ii. contain interventions to weaken or reduce the behaviors that provoked restraint that were based on the functional assessment results.
    iii. Have evidence that each was implemented with integrity
c. 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.

7. All restraints should be reviewed by both the unit director and IMRT within three business days of the restraint incident (C8).

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 #002.4, dated 11/20/12 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021.2 dated 12/4/12 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 Acknowledgement to report abuse for all employees hired within the last 2 months 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 FY13 o Injury Trend Reports FY13 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 A sample of acknowledgement to self report criminal activity for 24 current employees o ISPs for: • Individual #360, Individual #43, Individual #449, Individual #161, Individual #169, Individual #120, Individual #504, Individual #560, Individual #98, and Individual #475. 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 10/1/12 including case disposition o List of all investigations completed by the facility since 10/1/12 o List of employees reassigned due to ANE allegations o List of staff who failed to report ANE, or failed to report in a timely manner o Documentation of employee disciplinary action taken with regards to the last three incidents of confirmed abuse or neglect. o Documentation from the following completed investigations, including follow-up:

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#42743096	Emotional/Verbal Abuse	Unconfirmed	5/12/13 8:22 pm	5/14/13 12:30 pm	5/17/13
#42735661	Physical Abuse	Unconfirmed	5/6/13 10:20 am	5/7/13 10:47 am	5/16/13
#42735393	Physical Abuse	Confirmed	5/5/13 9:42 pm	5/7/13 10:47 am	5/24/13
#42735114	Emotional/Verbal Abuse	Unfounded	5/5/13 10:33 am	5/5/13 5:00 pm	5/15/13
#42734671	Neglect (2)	Confirmed (1) Unconfirmed (1)	5/4/13 11:07 am	5/5/13 4:26 pm	5/14/13
#42733108	Physical Abuse	Unconfirmed	5/2/13 5:54 pm	5/3/13 10:53 am	5/12/13
#42728316	Neglect (2)	Unconfirmed (2)	4/29/13 12:46 pm	4/20/13 11:58 am	5/6/13
#42717381	Neglect	Inconclusive	4/18/13 12:45 pm	4/19/13 10:45 am	4/29/13
#42715718	Physical Abuse (4)	Unconfirmed (4)	4/17/13 10:11 am	4/17/13 1:59 pm	5/17/13
#42701043	Neglect	Unconfirmed	4/3/13 2:28 pm	4/4/13 11:15 am	5/1/13
#42672564	Physical Abuse	Confirmed	3/5/13 6:53 am	3/5/13 9:44 pm	3/25/13
#42657234	Physical Abuse	Confirmed	2/17/13 8:07 am	2/19/13 2:41 pm	3/6/13
#42656128	Physical Abuse	Unconfirmed	2/15/13 2:11 pm	2/16/13 1:20 pm	3/7/13
#42638474	Physical Abuse	Unconfirmed	1/30/13 4:09 am	2/1/13 11:56 am	2/9/13
#42599054	Neglect (5)	Unconfirmed (3) Confirmed (2)	12/22/12 4:35 pm	12/23/12 10:45 am	1/11/13
#42526721	Exploitation Sexual Abuse	Other Confirmed	10/25/12 3:42 pm	10/29/12 2:53 pm	11/5/12
#42460480	Exploitation Neglect Sexual Abuse	Inconclusive Confirmed Confirmed	9/11/12 8:14 pm	9/11/12 9:40 pm	9/18/12

Sample D.2	Type of Incident	DFPS Disposition	Date of DFPS Referral	DFPS Completed Investigation	Facility Completed Investigation
#42742573	Neglect	Referred Back	5/11/13	5/14/13	
#42691263	Neglect	Referred Back	3/24/13	3/28/13	
#42651015	Exploitation	Referred Back	2/11/13	2/12/13	
#42617660	Neglect	Referred Back	1/11/13	1/15/13	
#426175	Physical Abuse	Referred Back Rights Issue	1/11/13	1/22 13	
Sample D.3	**Type of Incident**	**Date/Time Incident Occurred**			
#1903	Serious Injury-Determined Cause	5/20/13 10:30 am			
#1895	Serious Injury-Determined Cause	5/16/13 11:00 am			
#1883	Serious Injury-Determined Cause	4/7/13 6:00 pm			
#1783	Sexual Incident	4/4/13 5:45 pm			
#1680	Sexual Incident	3/4/13 Unknown time			
#1646	Sexual Incident	2/14/13 Unknown time			
#1553	Serious Injury – Peer to Peer Aggression	1/10/13 12:30 pm			
#1281	Serious Injury – Peer to Peer Aggression	9/18/12 1:45 pm			

Interviews and Meetings Held:

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

	Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 6/3/13 and 6/5/13 o ISP preparation meeting for Individual #589 o Annual IDT Meeting for Individual #278 and Individual #398 o Longhorn Unit Meeting 6/4/13
	Facility Self-Assessment: MSSLC submitted its self-assessment. Along with the self-assessment, the facility had two other 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. The second document 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 D2a, the facility reviewed the investigations to ensure all incidents were reported to the appropriate parties and reviewed by the facility review authority when completed. A monthly sample of the section D audit tool was completed and reviewed by the IMC The facility's review of its own performance found compliance with 21 of 22 provisions of section D. The exception was D4. The monitoring team found the facility to be in substantial compliance with 19 of the 22 provision items. The monitoring team was unable to confirm compliance with the requirement that • Staff completed competency based training at least annually (D2c); • The facility implemented action promptly and thoroughly, and tracked actions and the corresponding outcomes following unusual incidents (D3i). • Corrective action was taken to address trends of incidents and injuries (D4). The facility is to be commended for its continued focus on developing an adequate self-assessment process to monitor compliance with section D requirements.
	Summary of Monitor's Assessment: According to a list provided by MSSLC, DFPS conducted investigations involving 485 allegations at the facility between 9/1/12 and 4/30/12, including 340 allegations of physical abuse, seven allegations of exploitation, and 140 allegations of neglect. Of the 485 allegations, there were six confirmed cases of physical abuse and five confirmed cases of neglect. An additional 328 other serious incidents were investigated by the facility. There were a total of 1011 injuries reported between 9/1/12 and 2/28/13. These 1011 injuries included 22

	serious injuries resulting in fractures or sutures. Injury trends were being generated by individual and made available to IDTs for access on the shared drive. The facility made progress in addressing compliance with section D, though minimal progress had been made in adequately following up on incidents by addressing factors contributing to the large number of incidents and injuries at the facility. The facility will need to make appropriate recommendations with a focus on systemic issues that were identified through trend analysis. The incident management department was playing an integral role at the facility in looking at trends and systemic issues that contribute to incidents and individualized supports and services that place individuals at risk. IDTs now need to ensure that when individuals are at risk, adequate supports are provided and outcomes are monitored.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The facility policy stated that 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:		

#	Provision	Assessment of Status	Compliance
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	According to MSSLC Incident Management Policy 002.3, staff was 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 • Unauthorized departures. The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This was consistent with the requirements of the Settlement Agreement. Although in the paragraphs that follow, the monitoring team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken. The facility's progress in analyzing data collected, and addressing issues identified is discussed in D.4 below. Based on responses to questions about reporting, eight of eight (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Based on responses to questions about reporting, eight of eight (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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. Based on a review of 30 investigation reports included in Samples #D.1 and #D.2, 30 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. According to a summary of all abuse, neglect, and exploitation investigations between 9/1/12 and 4/30/12 provided to the monitoring team, investigations of 485 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility. From these 485 allegations, there were: • 340 allegations of physical abuse including, o 6 confirmed; o 157 unconfirmed; o 13 inconclusive; o 143 unfounded; o 1 administrative referrals; o 7 information and referrals; and o 11 pending outcomes. • 143 allegations of neglect including, o 5 confirmed; o 73 unconfirmed; o 16 unfounded; o 9 inconclusive; o 24 administrative referral; o 3 clinical referral; o 1 information and referral; and o 12 pending outcomes. • 7 allegations of exploitation including, o 2 unconfirmed; o 2 administrative referrals; o 1 inconclusive; o 1 merged; and o 1 pending outcome. According to a list provided by the facility, there were 328 other investigations of serious incidents not involving abuse, neglect, or exploitation between 9/1/12 and 4/30/13. This included:	

#	Provision	Assessment of Status	Compliance
		o 1 choking incident o 56 serious injuries/determined cause, o 14 sexual incidents, o 19 unauthorized departures, o 2 deaths, o 7 suicide threat, o 3 encounters with law enforcement, and o 46 others unspecified. From all investigations since 9/1/12 reported by the facility, 30 investigations were selected for review. The 30 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 facility investigation 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 (8 cases). Based on a review of the 17 investigative reports included in Sample #D.1: • 11 of 17 reports in the sample (65%) indicated that DFPS was notified within one hour of the incident or discovery of the incident. For five incidents not reported within an hour, there was no evidence that the staff suspected abuse or neglect at the time of the incident. o Investigation #42626721 involved a confirmed allegation of sexual abuse witnessed by other staff. It was not reported to DFPS until the following day. • For the one allegation for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the UIRs/investigation folders did not include recommendations for corrective actions. • 15 (88%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/facility policy. o 16 of 17 (94%) indicated the facility director or designee was notified of the incident. The facility did not document notification for DFPS case #42599054. o In two cases, notification did not occur within the one hour required by state policy. The exceptions were DFPS case #442734671, and DFPS case #42735393. o 15 of 15 (100%) indicated OIG or local law enforcement was notified	

#	Provision	Assessment of Status	Compliance
		within the timeframes required by the facility policy when appropriate. o 16 of 17 (94%) documented that the state office was notified as required. One UIR did not document notification of the state office (DFPS case #42735114). Based on a review of eight investigation reports included in Sample #D.3 (serious incidents), documentation indicated: • Six of eight (75%) were reported immediately (within one hour) to the facility director/designee when the incident was discovered or deemed serious. o UIR #1183 involved a serious injury that was not reported for investigation until the following day. The physician failing to report that injury within required time frames was retrained on reporting procedures. o UIR #1646 involved a sexual incident reported to staff on the day of the incident. Staff failed to report the incident until three days later. A second staff person reported the incident to the campus coordinator rather than the appropriate designee. Both staff received written warnings. o Documentation of state office notification, as required by state policy, was found in five of eight (63%) UIRs. Exceptions were UI #1903, UI #1883, and UI #1553. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. 70 of 72 (97%) new employees hired since 4/1/13 signed this form when hired. All employees were required to sign an acknowledgement form annually. A sample of this form was a random sample of 24 employees at the facility. Twenty-three of 24 employees (100%) in the sample signed this form annually as required by state policy. 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	The facility had 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. The monitoring team was provided with a log of employees who had been reassigned between 10/1/12 and 5/13/13. The log included the applicable investigation case number, date of reassignment, disciplinary action taken (including retraining), and the date the employee was returned to work.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	Based on a review of 15 investigation reports included in Sample D.1, in 14 out of 15 cases (93%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status immediately. • For DFPS case #42735114, documentation was not found indicating when the AP was removed from the home. All allegations were discussed in the daily IMRT meeting and protections were reviewed. In 17 out of 17 cases (100%), there was no evidence that the employee was returned to 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 c placing the AP in a position of no client contact, an emotional assessment, a head-to-toe assessment by a nurse, and changes in level of supervision when applicable. 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 seven employees hired within the past year. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 18 (100%) of 18 employees (employed over one year) with current training completed this training within 12 months of the date of previous training unless documentation indicated that the employee was on leave. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 15 (83%) of the 18 employees (employed over one year) with current training completed this training within 12 months of the date of previous training unless documentation indicated that the employee was on leave.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 had not maintained compliance with the requirement for annual retraining according to the sample reviewed. The facility was not in substantial compliance with this provision.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter after completing ABU0100 training. A sample of this form was reviewed for a random sample of 24 employees at the facility. 24 (100%) of 24 employees in the sample had a current signed acknowledgement form. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility reported that there were no cases where staff failed to report abuse or neglect as required. Investigation #42626721 involved a confirmed allegation of sexual abuse witnessed by other staff. It was not reported to DFPS until the following day. The UIRs/investigation folders did not include recommendations for corrective actions. The monitoring team assigned a substantial compliance rating to this provision.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual 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 10 ISPs was reviewed for compliance with this provision. The sample ISPs were for Individual #360, Individual #43, Individual #449, Individual #161, Individual #169, Individual #120, Individual #504, Individual #560, Individual #98, and Individual #475. • Ten (100%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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, most individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. The facility was in substantial compliance with this item.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • Individuals' rights, • Information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of all living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There was a human rights officer at the facility. Information was posted around campus identifying the human rights officer with her name, picture, and contact information. The HRO was actively involved in educating individuals about their rights through the facility's self-advocacy group. 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/or OIG of the allegation in 15 (100%), when appropriate. OIG investigated nine cases in the sample and criminal activity was substantiated in two of nine (22%) cases. The facility remained in substantial compliance with this provision item.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	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. No names were submitted. Based on a review of investigation records (Sample #D.1), there were no concerns related to potential retaliation for reporting. The facility maintained substantial compliance with this item.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The facility had implemented an injury audit process to determine if all injuries that should have been reported for investigation were investigated. This included those injuries defined in DADS policy as "serious injuries" as well as non-serious injuries on parts of the body that might indicate potential abuse or neglect, or patterns of minor injuries both witnessed and discovered Reviews included a sample of Integrated Progress Notes, Home/Shift Logs, Observation Notes, and Campus Coordinator Logs to identify any incidents that should have resulted in completing a Client Injury Report, and a comparison to determine if incident reports were filed. The facility conducted audits at least quarterly, during the preceding six months. The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation. No significant injuries identified by the audit that had not previously been investigated. Based on interviews with the Incident Management Coordinator and a sample of completed injury audits, the facility's audit system was adequate for ensuring that all discovered and/or suspicious injuries were reviewed to rule out abuse or neglect. The facility was in substantial compliance with this provision item.	Substantial Compliance

#	Provision	Assessment of Status	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:		
	(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. Thirteen 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 10 employees designated to complete investigations. This included the IMC, facility Investigators, and Campus Administrators. The training records for those designated to complete investigations were requested, 10 (100%) investigators had completed training on: • Abuse, Neglect, and Exploitation, • Unusual Incidents, • Root Cause Analysis, and • Comprehensive Investigator Training. 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,	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

#	Provision	Assessment of Status	Compliance
	and exploitation.	The facility incident management coordinator reported good cooperation between the facility incident management staff and DFPS. DFPS investigators had been given office space at the facility to expedite the investigation process.	
	(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), OIG investigated nine of the incidents. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility was found to be in substantial compliance with this provision.	Substantial Compliance
	(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

#	Provision	Assessment of Status	Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	<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 10 of 17 (59%) investigations. o 17 (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. • Nine of 17 (53%) were completed within 10 calendar days of the incident. Those not completed within 10 days included: o Case #42735393 was submitted on the 19th day (extension filed – OIG involvement). o Case #42715718 was submitted on the 30th day (extension filed- OIG involvement). o Case #42701043 was submitted on the 18th day (extension filed – waiting on medical records and additional interviews). o Case #42672564 was submitted on the 19th day (extension filed – additional witnesses need to be interviewed). o Case #42657235 was submitted on the 17th day (extension filed – additional witnesses need to be interviewed). o Case #42656128 was submitted on the 20th day (extension filed – conflicting testimony/additional interviews needed). o Case #42599054 was submitted on the 18th day (extension filed - conflicting testimony/additional interviews needed). o Case #42526721 was submitted on the 11th day (no extension filed) • 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 20 of 22 (91%) DFPS investigations reviewed in Sample #D.1 and #D.2, concerns or recommendations for corrective action were included. Five of those cases resulted in a referral 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: • The investigation began within 24 hours of being reported in eight of eight cases (100%). • Seven of eight (88%) indicated that the investigator completed a report within 10 days of notification of the incident.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• Although it appeared that reports were completed in a timely manner, it was difficult to determine when the written report was submitted. The UIR included a completion date, though in some cases, investigation activities occurred after this date. Additionally, investigators did not sign and date the completed investigation. Examples of this were: o UIR #1883 showed a completion date of 5/9/13. Witness statements were taken on 5/10/13 and 5/13/13. The facility review indicated that the report was submitted on 5/20/13 (the 11th day). o UIR #1646 indicated that the final review by the IMC, IMRT and director occurred on 2/20/13. The summary included witness statements taken on 2/22/13 and 2/25/13. • Five of eight (63%) included recommendations for follow-up action to address the incident. Substantial compliance was met, however, the monitoring team recommends that facility investigator sign and date all UIRs when completed.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the	Based on the monitoring team's review of DADS revised Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. The facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In 17 out of 17 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. ▪ The report utilized a standardized format that set forth explicitly and separately: o In 17(100%), each unusual/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; 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 In 12 (71%), all sources of evidence considered, including previous	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. DFPS found in each case that prior case history of principals was reviewed and not deemed relevant. Facility UIRs, however, in some cases included a summary of previous investigations with a statement regarding the outcome of those investigations. Exceptions were DFPS Case #42526721, DFPS Case #42638474, DFPS Case #42734671, DFPS Case #42735393, and DFPS Case #42735661 The facility should review all previous allegations and summarize their findings in regards to relevancy. 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 facility investigations: • In eight out of eight investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The facility was in substantial compliance with this item.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The facility policy and procedures required that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete, and coherent. <u>DFPS Investigations</u> The following summarizes the results of the review of a sample of 11 DFPS investigations included in Sample #D.1: • In 17 (100%) investigative files reviewed from Sample #D.1, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. • The DFPS investigations in Sample D.1 met at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f; • The facility Incident Review Team (IRT) accepted all (100%) investigations in the sample. • The monitoring team did not note problems with regard to Sections D.3.e, and/or D.3.f for DFPA investigations in the sample. 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, • 17 (100%) DFPS investigations were reviewed by both the facility director and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		IMC following completion. • 17 (100%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations in samples #D.1 and #D.2: • In 12 out of 13 investigation files reviewed (88%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. o UIR #1646 indicated that the final review by the IMC, IMRT and director occurred on 2/20/13. The summary included witness statements taken on 2/22/13 and 2/25/13. • The supervisor did not identified concerns in any of the investigations. • The Monitoring Team did not identify deficiencies in any of the investigations. 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. The facility was in substantial compliance with the requirement for review of all investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent.	
	(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 30 out of 30 (100%) unusual incidents reviewed. A statement regarding review, recommendations, and follow-up was included on the review form. The facility-only investigations met the requirements outlined in Section D.3.f.	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	The facility policy and procedures required disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. The IMRT considered and accepted or provided a reason for not accepting recommendations in the DFPS or UIR reports.	Noncompliance

#	Provision	Assessment of Status	Compliance
	promptly and thoroughly, and track and document such actions and the corresponding outcomes.	In addition, the policy and procedures did specify the facility system for tracking and documenting such actions and the corresponding outcomes. A subsample of investigations was reviewed to confirm that appropriate disciplinary action was taken following the investigation when warranted. This sample included DFPS cases #42743096, #42734671, #42599054,#42526721, #42728316, #42733108, #42672564, and #42657234 For seven out of eight of the investigations reviewed in which disciplinary action was warranted (88%), prompt and adequate disciplinary action had been taken and documented. • In DFPS Case #42672564, the investigator returned a confirmed allegation of abuse against the AP. Video surveillance and eye witness accounts corroborated the finding. The AP grabbed the individual behind the neck and forced him to the ground during a behavioral incident. The AP received a two day suspension for his actions. This did not support the facility's policy of zero tolerance for abuse and neglect. Based on a review of a subsample of investigations (listed above) and those in Sample #D.2 referred back to the facility for which recommendations for programmatic action were made, the following was found: • For five out of seven of the investigations reviewed (71%), prompt and thorough programmatic action had been taken and documented. o For DFPS #42734671, follow-up was documented for two of four recommendations. #42617660, o For DFPS #42617660, the investigator recommended programmatic action in regards to the aggressor in the sexual incident. There were no recommendations to address any trauma that the alleged victim may have experienced due to the incident. • For none of the investigations (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified. The facility did not have a system to confirm that expected outcomes were achieved, and this process was not documented for recommendation (e.g., based on retraining, staff had passed a competency test or during interview could provide relevant information; observation of a change in physical environment; observation or documentation review to confirm a change in practice; behavioral data showing a change in behavior; etc.).	

#	Provision	Assessment of Status	Compliance
		The facility was not yet following up on all recommendations, documenting follow-up action, and monitoring outcomes of the action for investigations. In an attempt to prevent the likelihood of serious incidents from occurring, the facility needs to ensure that adequate follow-up occurs for all incidents. 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
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 fully implemented the statewide system to collect data on unusual incidents and investigations. For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending 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 investigation. Over the past two quarters, the facility's trend analyses: • Were conducted at least quarterly; and • Addressed the minimum data elements. • A narrative description/explanation of the results and conclusions was not generated; and • Recommendations for corrective actions were not made. Based on a review of trend reports, IMRT minutes, and QA/QI Council minutes, when a negative pattern or trend was identified, corrective action plans were not developed. As appropriate, corrective action plans were not developed both for specific individuals and at a systemic level.	Noncompliance

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The trend reports and minutes did not show that corrective action plans were implemented and tracked to completion.

The report and minutes did not review, as appropriate, the effectiveness of previous corrective actions.

As appropriate, corrective action plans should be developed in response to the trends data analysis. The plans should identify the strategies the facility intends to implement to reduce the risk of similar events occurring in the future for specific individuals, as well as at a systemic level. Each corrective action plan should identify:
a. Changes to be implemented to reduce risk or a referral to another group to develop such a plan, such as a referral for an IDT meeting, or review by PNMT. Such changes should be expected to correct the identified issue. When referrals are made to other groups, a process should be in place to ensure the IMRT and/or QAQI Council review/approve the resulting plan, and will be provided follow-up information;
b. Who is responsible for implementation and when the action will be implemented, including any pilot testing. Timeframes should be reasonable based on the seriousness of the issue and the time necessary for the action to be completed; and
c. The method for assessing the effectiveness and sustainability of the actions.

It was not evident that trends were being addressed with adequate changes in supports when needed. For example, Individual #508's IDT met numerous times between 1/18/13 and 4/10/13 to review trends related to peer-to-peer aggression and injuries. Supports were not revised when not effective and action steps were not developed to attempt to prevent similar incidents. Incidents of peer-to-peer aggression and injuries were routinely reviewed during both unit meetings and IMRT meetings. Follow-up was assigned to the IDT. The following is a summary of IDT meetings to address trends for Individual #508.
<table>
<tr><th>Date of IDT meeting</th><th>Incidents reviewed</th><th>Supports in place</th><th>IDT Comments/ Recommendations</th></tr>
<tr><td>1/18/13</td><td>12/12/12 physical altercation with peer causing injury to self

1/02/13 physical altercation with peer causing injury to self</td><td>1:1 LOS 6am-10pm

BSP</td><td>Continue

Team agrees plan is still appropriate</td></tr>
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#	Provision	Assessment of Status				Compliance
		2/1/13	1/17/13 altercation with peer resulting in serious injury to peer 2/1/13 altercation with peer	1:1 LOS 6am-10 pm BSP	No changes made Team agrees plan is still appropriate.	
		2/12/13	2/11/13 hit by peer. Has swollen left eye 2/12/13 physical altercation with peer. Has an abrasion on elbow.	1:1 LOS 24 hours a day (increased on 2/11/13 following altercation) BSP	Reduce LOS to 1:1 6am-10pm Team agrees BSP is still appropriate	
		2/19/13	2/18/13 attacked peer causing several abrasions to head and face of peer.	1:1 LOS 24 hours a day (increased on 2/18/13 following altercation) BSP	Reduce LOS to 1:1 6am-10pm Team agrees BSP is still appropriate	
		2/27/13	2/20/20 abrasion to thumb caused by slip/fall/trip 2/25/13 knot on head caused by SIB 2/25/13 skin tear to index finger caused by SIB	1:1 LOS 6am-10pm	Encouraged individual to exhibit good behavior and do not cause any injuries to himself and/or others. He agreed. Continue 1:1 Team acknowledges 3 or more injuries within a 30 day period.	

#	Provision	Assessment of Status				Compliance
		3/6/13	Met to review restraint incident on 3/5/13 due to peer to peer aggression.	1:1 LOS 6am-10pm	Supervision should remain the same Incident occurred when individual was at home. Individual reported that he refused to go to life-skill classes because he did not like instructor. Team explained that he should try to go and not refuse.	
		3/13/13	3/12/13 punched peer in the mouth	1:1 LOS 24 hours a day BSP	Continue Team agrees BSP is still appropriate	
		3/20/13	3/12/13 skin tears on knuckles due to altercation with peer 3/17/13 abrasions to mid forehead, back of head and bridge of nose due to SIB 3/18/13 laceration to scalp caused by SIB	1:1 LOS BSP	Team acknowledged 3 or more injuries within a 30 day period. No changes to supports.	
		3/27/13	3/21/13 abrasions to mid chest, bruise to thigh due to SIB 3/24/13 superficial laceration caused by peer	1:1 LOS 24 hours a day BSP	Team encouraged individual to stop hurting himself and getting in altercations with his peers.	

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<tr><td></td><td>3/25/13 reopened laceration to head due to SIB

3/26/13 injury to right index finger</td><td></td><td></td></tr>
<tr><td>4/10/13</td><td>4/1/03 open area to mid head/scalp, area swollen, bruising and redness to ear lobe caused by SIB

4/3/13 redness and swelling to right eye caused by peer

4/8/13 abrasion to left eye caused by peer</td><td>1:1 LOS 24 hours a day (increased on 4/8/13 following altercation)

BSP</td><td>Reduce LOS to 1:1 6am-10pm

Team agrees BSP is still appropriate

Team acknowledges 3 or more injuries within a 30 day period.</td></tr>
</table>

The facility had made significant progress in identifying incident trends at the facility. Using trend data to develop supports is a new process for the IDTs. IDTs at MSSLC were still learning how to best use this information to develop and implement supports. IDTs need to aggressively address trends in injuries and implement protections to reduce these incidents and injuries.</td><td></td></tr>
<tr><td>D5</td><td>Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for</td><td>By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment:
Criminal background check through the Texas Department of Public Safety (for Texas offenses)
An FBI fingerprint check (for offenses outside of Texas)
Employee Misconduct Registry check
Nurse Aide Registry Check
Client Abuse and Neglect Reporting System
Drug Testing
Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks.</td><td>Substantial Compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
	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.	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 FY13, criminal background checks were submitted for 1170 applicants. There were 70 applicants who failed the background check in the hiring process and therefore was 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 24 of 24 employees (100%). The facility remained in substantial compliance with this provision item.	

Recommendations:

1. The facility needs to ensure that staff complete training annually as required by the settlement agreement and state policy (D2c).
2. The facility investigator should sign and date all completed investigations verifying his/her submission of the completed investigation (D3e).
3. Whenever 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).
4. As appropriate, corrective action plans should be developed in response to the trends data analysis. The plans should identify the strategies the facility intends to implement to reduce the risk of similar events occurring in the future for specific individuals, as well as at a systemic level. (D4).

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS policy #003.1: Quality Enhancement, dated 1/26/12 o MSSLC facility-specific policies: • Quality Assurance Adm-37 4/1/12, Participating in PIT Monthly Meeting CC-42 5/29/13 (updated the participation requirement), Participating in PET Monthly Meeting CC-36 4/25/12, and QAQI Council. o MSSLC organizational chart, 5/17/13 o MSSLC policy lists, May 2013 o List of typical meetings that occurred at MSSLC, undated but likely May 2013 o MSSLC Self-Assessment, 5/17/13 o MSSLC Action Plans, 5/17/13 o MSSLC Provision Action Information, most recent entries 5/21/13 o MSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 6/3/13 o QA director's worksheet based upon the last monitoring report, undated o List of all QA department staff and their responsibilities, undated but likely May 2013 o MSSLC QA department meeting notes, monthly January 2013 - April 2013 (4 meetings) o MSSLC data listing/inventory, hard copy (no electronic version), 4/22/13 o MSSLC QA plan narrative, undated, probably May 2013 o MSSLC QA plan matrix and QAQI Council schedule, undated, probably May 2013 o Set of blank tools used by QA department staff (2 tools) o Sets of completed tools used by QA department staff (none) o Trend analysis report, for all four components, last two quarters requested; instead received some data for a four year period, and other data for varying quarters October 2012 to March 2013, no complete report with all four components o MSSLC DADS regulatory review reports, October 2012-April 2013 o CATW (check-ask-think-why) guidance for department heads to do an analysis of their data o QAD-SAC-section leader meeting summaries, December 2012, January 2013, and May 2013 (3) o Various packets of data and/or reports, such as regarding specific individuals, infection control, and environmental audits. o MSSLC QA Reports, 9/26/12 to 6/6/13 (12) o MSSLC QAQI Council monthly-quarterly key indicator presentation schedule, probably May 2013 o Executive Management Team, handout for 6/4/13 meeting o PIT meeting handout for Barnett, 6/5/13 o PIT meeting minutes and data sets for each unit for past five months, December 2012 to April 2013 o PET IV meeting handout for 6/5/13 o PET meeting minutes and handouts for each PET group for past six months, November 2012 to

	April 2013 o QAQI Council meeting handout for 6/6/13 o QAQI Council minutes, 11/8/12 to 5/9/13, 9 meetings o MSSLC Corrective Action Plan info: tracking 2 pages, 2 packets of active CAPs, CAP implementation form o DADS SSLC family satisfaction survey online summary, 11/12 through 4/13, 40 respondents o Individual satisfaction survey results, 17 respondents, March 2013-May 2013 o Self-advocacy monthly meeting minutes/notes, monthly October 2012 to April 2013, indicating inactivity due to lack of attendance/interest. o Home meeting agenda and notes, last two from each home, April 2013-May 2013 o Facility newsletters, The Family Press, January 2013 through April 2013 (2); and Focus, November 2012 through April 2013 (6) <u>Interviews and Meetings Held</u>: o Kim Kirgan, Director of Quality Assurance o Etta Jenkins, Settlement Agreement Coordinator 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: Barnett, 6/5/13 o PET IV meeting, 6/5/13 o QAQI Council meeting, 6/6/13 o Executive Management meeting, 6/4/13 o Self-advocacy meeting, 6/4/13 o Longhorn unit morning meeting, 6/6/13
	Facility Self-Assessment The QA director made a number of changes to the self-assessment for E1. The self-assessment for the other four provision items remained more or less the same. Perhaps for the next review, the self-assessments for E2 through E5 can be updated, too. The updated self-assessment for E1 was an improvement because it did a better job of following the items in the monitoring team's report and, therefore, provided information that was more in line with the monitoring team's findings. The QA director made a worksheet for her own use that detailed the many comments, suggestions, and recommendations from the previous monitoring report. This helped her in developing this self-assessment for E1. She also made improvements in the action steps and the provision action information report, as recommended in the previous monitoring report.

	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: The QA program at MSSLC made progress from the time of the last onsite review. Many of the components of a QA program were initiated. The QA data list inventory was vastly improved since the last review, contained 23 topic areas, and was managed in an excel spreadsheet. Nineteen of the 20 provisions of the Settlement Agreement were included (all except for S). Some topic areas had fairly extensive listings. Some topic areas listed some, but clearly not all, of the data collected. Its validity and completeness should now be obtained. The QA plan narrative at the facility was improved, but was not current, complete, and adequate. The QA plan matrix was almost identical to what was submitted for the previous two monitoring reviews and needed much improvement. Progress was seen at MSSLC regarding the gathering and organization of data. Data from all 20 sections of the Settlement Agreement were summarized and graphed showing trends over time. The length of time (i.e., number of months), breadth of topics covered, and quality of the summation of the data varied greatly across these 20 sections and across the past six months. Monthly QAD-SAC meeting with discipline departments began since the last review. The QA report format and regular monthly production were improved from the time of the last review. Of the 20 sections of the Settlement Agreement, 10 (50%) appeared in a QA report at least once in each quarter. An area for improvement was for the section leaders to do more of an analysis of their data. The QAQI Council met at least once each month. Minutes from all QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics. An adequate written description did not exist that indicated how CAPs were generated, including the criteria for the development of a CAP. There were five CAPs; all five were regarding nursing services.

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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.	The QA program at MSSLC made progress from the time of the last onsite review. Many of the components of a QA program were initiated. <u>Policies</u> There was a state policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. There were no changes to the state policy, titled #003.1: Quality Assurance, dated 1/26/12. Positive aspects included: • It seems to have reserved policies for statewide development, and procedures for facility development. This will keep the terminology consistent and the facility should not have to re-label the state policy to adopt it. • It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. • The policy language was simple and straightforward and the bullet style will make it easy for staff to read. • It required disciplines to keep account of their databases and the QA department to keep track of all databases. Other comments: • The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the facilities to have procedures to deal with both. • There did not appear to be a list of key indicators or a directive to develop a list. • The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State office should consider this. There were not MSSLC facility policies that adequately supported the state policy for quality assurance. The QA director reported that the facility followed the state policy, however, the state policy did not provide the procedural detail that would be expected in a facility policy. The QA director could consider making the QA plan narrative (see below) the facility specific policy because, once complete, it should detail much of the facility specific QA activity. Once the facility-specific policy (or policies) is updated, training should be provided to QA department staff.	Noncompliance

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		QA Department Kim Kirgan continued in her role as QA director. She remained present and active at many meetings and presentations throughout the week of the onsite review. An excellent working relationship was now in place between Ms. Kirgan and the SAC. The QA director continued to hold one staff meeting per month. Topics were relevant to QA staff and their assignments and activities. The topics appeared to be a good way for the QA director to stay on top of the many special audits the department was conducting. Quality Assurance Data List/Inventory The QA data list inventory, an important component of a comprehensive QA program, was vastly improved since the last review. The data list inventory was 25 pages long, contained 23 topic areas, and was managed in an excel spreadsheet. Nineteen of the 20 provisions of the Settlement Agreement were included (all except for S). C and K; O, P, and R; and G, H, and L were combined into single list inventories. Even so, there was not yet a complete and adequate data list/inventory at the facility. Some topic areas had fairly extensive listings. Some topic areas listed some, but clearly not all, of the data that were being collected. All included self-monitoring tools on the list, which was good to see. Given that the facility had established the foundation of a data list inventory, its validity and completeness should now be obtained. Periodic review during the QAD-SAC meetings should help, as well as periodic presentations to QAQI Council. The monitoring team and the QAD discussed the possibility of presenting each data list inventory to QAQI Council every six months, perhaps spreading them out over the course of six months. Columns were added to the data list inventory indicating if the data were to be regularly reviewed at QAQI Council, included in the QA report, reviewed at QAD-SAC meetings, and/or reviewed by the QA department. This was all very good to see, however, if 100% of what was in the QA report was always to be presented at QAQI Council, there would be no need to have duplicative columns. The data listing was updated on 4/22/13, thus, the data list inventory, although not complete, was current. The date of the most recent review/update of each data list inventory page should have its own date because not all will be reviewed and updated on the same day. Quality Assurance Plan Narrative The QA plan narrative at the facility was improved, but was not current, complete, and	

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		adequate. The QA plan narrative was updated since the last review. It was four pages long and contained all of the sections recommended in the previous report. The content of each of these sections, however, was not fully updated to reflect current practice and expectations for the QA program at MSSLC. The QA plan narrative could be improved by describing how the most important key indicators for each discipline are determined. As noted above, the QA plan narrative might be considered to be a facility-specific policy. <u>QA Plan Matrix</u> The QA plan matrix was almost identical to what was submitted for the previous two monitoring reviews. 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. For the next review, the QA director should be prepared to demonstrate to the monitoring team that: 1. An adequate set of key indicators is included in the QA matrix for all 20 sections of the Settlement Agreement. 2. These key indicators include both process and outcome indicators for all of the 20 sections of the Settlement Agreement. 3. These indicators provide data that could be used to identify the information specified in E1: 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. The QA matrix should also include the self-monitoring tools used for each of the 20 sections of the Settlement Agreement. The MSSLC QA matrix listed self-monitoring tools for many of the 20 sections (80%), however, the monitoring team was aware of recent changes and revisions to many of the self-monitoring tools, and was also aware that many of the tools were no longer being used in the way indicated in the matrix. The QA director needs to update this part of the QA plan matrix. All data that QA staff members collected were not listed in the matrix. QA staff members collected only one (or possibly two) types of data themselves. One of the two was included in the data list inventory, but not on the QA matrix. The QA director reported that data for the one measure were presented quarterly, but the monitoring team could not find it in any of the documentation.	

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		Satisfaction surveys were not included in the QA matrix. • An individual satisfaction survey was developed and implemented with 17 individuals. Overall, the results were positive, though some of the questions indicated areas for possible improvement, discussion, and/or education. Certainly some follow-up should occur. • Self-advocacy activities can be one way of obtaining satisfaction information from individuals. The self-advocacy group, under the guidance and facilitation of Joy Lovelace, the HRO, continued to struggle to have any consistent or meaningful attendance. Some changes were implemented during the week of the onsite review. • At MSSLC, weekly home meetings for individuals and their staff were held. Minutes/agendas indicated relevant topics were always discussed, including preferred activities, announcement, and skill development. It appeared that the organization and content of these meetings had improved since the last onsite review. • The statewide family/LAR satisfaction survey was implemented. Across the past six months, the reports contained lots of interesting comments, but there did not appear to be any follow-up, even though many comments seemed to warrant some follow-up. The reports might be combined into a single six month report to make it easier for the reader. Also, many responses appeared to be from family members of individuals from other SSLCS because there were references to Abilene, RSS, Three Rivers, and TJ6, none of which are locations at MSSLC. • There was no community business satisfaction survey or staff satisfaction survey. The QA matrix is really a subset of the larger data list/inventory. Therefore, all items on the data matrix should also be in the data list inventory. That was not case for most of the items on the items. Moreover, items in the data list/inventory that were regularly in the QA report and presented to QAQI Council were not in the QA matrix. It seemed that the QA matrix was not updated, or perhaps not used at all. The QA director reported in her personal worksheet that the QAQI Council determined what data would be presented at QAQI Council meetings from each department. The monitoring team, however, could find no evidence or examples of this occurring in any of the minutes, attachments, data, or discussion during the QAQI Council observed by the monitoring team.	

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		QA Plan Implementation Items in the QA plan matrix should be implemented as written, submitted, and reviewed. Therefore, the QA director should indicate which of the items in the QA matrix were: 1. Submitted/collected/received by the QA department for the last two reporting periods for each item 2. Reviewed or analyzed by the QA department and/or the department section leader 3. Conducted as per the schedule. A percentage can also be calculated, perhaps monthly, bi-monthly, or quarterly, for each of the three items in the list above. Documentation and observation did not indicate that QA staff assisted each discipline in analysis of data, or if there was no assistance provided, there was documentation that it was not needed. Self-Monitoring Tools The use of self-monitoring tools was an important component of the self-assessment activity at all of the SSLCs and had been so for the past few years. A great deal of importance was placed on these tools and their outcomes. Thus, much attention from the QA department and QAQI Council continued to be directed to self-monitoring tools. Facilities can develop their own tools (or modifications of state-provided tools) for each of the Settlement Agreement sections. As far as the monitoring team could determine, at MSSLC, only the tools for sections O and S were modified from the original statewide forms. The QA director reported in her personal worksheet that she had told each discipline head that he or she could modify or develop anew, his or her department's self-monitoring tools. As the QA director and the department section leaders work towards improving their self-monitoring tools, the monitoring team recommends that they review the comments made in previous monitoring reports regarding these tools. Further, for the next onsite review, the QAD should be prepared to present to the monitoring team information regarding the following aspects of the self-monitoring tools at MSSLC: 1. Content/validity: A description of how the content of the tools was determined to be valid (i.e., measuring what was important) and that each tool received a review sometime within the past six months. 2. Adequate instructions: A description of how it was determined that the instructions given to the person who was to implement each of the tools were adequate and clear. 3. Implementation: A report or summary showing whether the tools were	

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		implemented as per the QA matrix. 4. QA review: A report or summary showing that there was documentation of QA department review of the results, at least once each quarter, for each of the 20 sections of the Settlement Agreement. This may be now occurring during the QAD-SAC meetings.	
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.	Progress was seen at MSSLC regarding the gathering and organization of data. Data from 20 of the 20 (100%) sections of the Settlement Agreement were summarized and graphed showing trends over time. To make this determination, the monitoring team reviewed the QA reports, minutes from QAQI Council, and the handouts presented at QAQI Council. The length of time (i.e., number of months), breadth of topics covered, and quality of the summation of the data varied greatly across these 20 sections and across the past six months. As noted above in E1, there was still a need to: • Review the content of many of the self-monitoring tools and update the tools or create new tools, if needed. • Demonstrate that there was adequate and thorough identification of the important data/indicators for each section of the Settlement Agreement. • When appropriate to do so, for each section, provide an analysis across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as required by this provision. <u>Monthly QAD-SAC meeting with discipline departments</u> These meetings began since the last onsite review. Initial meetings in December 2012 and January 2013 were designed to introduce discipline departments to the goals and expectations of these meetings. The meetings occurred once each month. There were 41 of these meetings that covered all 19 of the Settlement Agreement provisions. The QA director should ensure that the topics listed the four metrics below are always touched upon. Moreover, the QAD-SAC meeting may also be a forum to address (and document) an analysis across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as required by this provision. 1. Since the last onsite review, a meeting occurred at least twice for 19 of the 19 (100%)	Noncompliance

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		sampled sections of the Settlement Agreement. All five topics below were conducted during 0 of the 41 (0%) meetings that occurred. One or more of these five topics, however, was discussed at all (100%) of the meetings. • Review the data listing inventory and matrix, • Discuss data and outcomes (key process and outcome indicators), • Review conduct of the self-monitoring tools, • Create corrective action plans, • Review previous corrective action plans. 2. Since the last onsite review, during 0 of the 41 (0%) meetings, data were available to facilitate department/discipline analysis of data. 3. Since the last onsite review, during 0 of the 41 (0%) meetings, data were reviewed and analyzed. 4. Since the last onsite review, during 3 of the 41 (7%) meetings, action plans (and/or CAPs) were created for systemic problems and for individual problems, as identified. <u>Other QA-Related Meetings</u> The facility held other meetings that were related to quality assurance. • Unit level monthly PIT meetings: These meetings continued each month as described in the previous two reports. The monitoring team reviewed minutes and data from these meetings for the past five months, attended the Barnett meeting while onsite, and spoke with the QA director and the facility's unit directors. These meetings were described as useful and informative during the previous onsite reviews, but at this time were described as no longer being necessary. Therefore, the QA director should explore this with the unit directors and senior administration (e.g., ADOP, facility director). It may be that the data reviewed at the unit PIT meetings were being reviewed regularly in other forums, or it may be that the daily morning unit meetings could be modified to ensure that all relevant data were being reviewed. This was raised as a topic in the 1/24/13 QAQI Council meeting, but it did not seem that any follow-up occurred, though it was noted by the QA director during the opening presentation to the monitoring team. • Section group monthly PET meetings: These meetings continued to occur and appeared to play an important role in the department leaders' assembling and preparation of data, and in their preparation of their presentation for an upcoming QAQI Council meeting. The monitoring team reviewed minutes and handouts from these meetings for the past six months, attended the PET IV meeting while onsite, and spoke with the QA director and SAC.	

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		• The QA department continued to have a number of data sets, such as regarding specific individuals, or regarding facility wide issues (e.g., within-facility transfers). 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 fit into the overall QA program, QA data listing inventory, QA plan narrative, QA plan matrix, QA report, etc. It appeared that some were in response to DADS regulatory reviews, some were in response to concerns raised by senior management, and some were from concerns raised by the QA department. <u>QA Report</u> The QA report was improved from the time of the last review. It was more organized and there was more consistency in presentation from month to month. Each month, there was at least one QA report, sometimes two. In the last six months, a facility QA report (for dissemination at the facility and for presentation to the QAQI Council) was created for six of the last six months (100%). Of the 20 sections of the Settlement Agreement, 10 (50%) appeared in a QA report at least once in each quarter (i.e., twice since the last onsite review). The 10 others (50%) appeared once in the six months. Of the 20 sections of the Settlement Agreement that were presented quarterly, one (3%) contained all of the components listed below (section D). Most contained three to seven months or more of data. Most included self-monitoring tool data. Nine included some break down by program areas, living units, etc. Seven (23%) contained some narrative analysis (sections D, M, N, Q, S, and I). • Self-monitoring data o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as appropriate • Other key indicators/important data for the section o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as appropriate • Narrative analysis An area for improvement was for the section leaders to do more of an analysis of their data. The QA director shared a one page guide that she said was given to department leaders to help them to do this analysis. It was called CATW (check-ask-think-why). It	

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		had five questions. The monitoring team could not determine if this was used by the department leaders or even helpful to them. This analysis would best be reflected in a paragraph or two in the QA report. <u>QAQI Council</u> This meeting plays an important role in the QA program. The monitoring team attended a meeting during the onsite review and read the minutes of all QAQI Council meetings from December 2012 through May 2013. There was an adequate description of the QAQI Council in the QA plan narrative. Since the last onsite review, the QAQI Council met at least once each month. Minutes from all (100%) QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics, such as the monthly and quarterly topics, performance improvement team reports, and the Settlement Agreement sections scheduled for presentation. Minutes from all (100%) QAQI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes (and attachments/handouts) from all (100%) of the QAQI Council meetings since the last review documented that (a) data from QA plan matrix (key indicators, self-monitoring) were presented, and (b) the data presented were trended over time. There was no indication, however, that (c) comments and interpretation/analysis of data were presented. The minutes did not, but should, reflect discussion that occurred. If there was no discussion or commentary, this should be indicated in the minutes, too. Similarly, the minutes should reflect if recommendations and/or action plans were discussed, suggested, or agreed to during each portion of the meeting. During a QAQI Council meeting observed by the monitoring team, there was active participation of participants other than the presenter for all (100%) of the reports/data for Settlement Agreement sections presented during the meeting (sections U and various committees).	

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		Corrective Actions The QA director had a two-page CAPs tracking document. It listed the five CAPs that the QA department was following, plus three DADS regulatory actions she was following, plus three other types of data the QA department was following, but for which there was no other information in the CAPs management system (LOS and environment, peer-peer aggression, environmental audit). Thus, there were a total of 11 items (5 CAPs, 3 regulatory, 3 QA department). Of these, six were marked as being completed (3 CAPs, 2 regulatory, 1 QA department). Of the five CAPs, all five had a detailed listing of steps to be taken (i.e., multiple actions). The responsible person directly entered update information into this listing. Of these five, two also had a two-page CAP implementation plan. An adequate written description did not exist that indicated how CAPs were generated, including the criteria for the development of a CAP. Therefore, when considering the full set of CAPs, the monitoring team could not determine if they were chosen following the written description, policy, or procedure. The CAPs addressed broader systemic issues, however, there were no specific (or general) criteria for CAPs. All 5 CAPs were regarding nursing services, further indicating that the use of CAPs was limited at MSSLC. The QA director reported that CAPs were going to be a regular topic at the monthly QAD-SAC meetings. Of the 5 CAPs reviewed by the monitoring team (100% of the total), 100 % appeared to appropriately address the specific problem for which they were created. Based on these 5 CAPs: • All (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. • 5 (100%) included the anticipated outcome of each action step. o However, there were no specific criteria to determine if the CAP was met, or if progress had occurred (0%). • 0 (0%) included the name of the person(s) responsible, however, all included the job title. • 5 (100%) included the time frame in which each action step must occur.	

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		Lastly, the monitoring team recommends that the QA director maintain and graph some simple data on CAPs. These data can be part of the section E data list inventory (and possibly the QA matrix, too). For example: • Total number of active CAPs • Number of CAPs completed and closed out for the month (or quarter) • Number of CAPs that are active (i.e., not completed) past their due date	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the CAPs tracking document of the 5 CAPs: • 0 (0%) included documentation about how the CAP was disseminated • 0 (0%) included documentation of when each CAP was disseminated, and • All 5 (100%) included documentation of to whom it was disseminated, but not the names of the specific persons responsible (0%).	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.	The five CAPs appeared to have been implemented (100%). The monitoring team, however, could not determine the following and will be looking for: • Indication that CAPs were implemented fully and in a timely manner. • An adequate system for tracking the status of CAPs (e.g., monthly) that indicates the status of the CAP and any action taken if a CAP had not been implemented. • Summary information/data regarding CAPs and their status that was updated within the month prior to the onsite review • Presentation of this information to QAQI Council at least quarterly.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The QA director did not have a method for evaluating the effectiveness of CAPs and for determining which CAPs needed modification. The monitoring team will be looking for: • Evaluation of the effectiveness of CAPs, including outcomes and timely completion • CAPs are modified when needed • Modifications/results are discussed at QAQI Council. • Modifications are implemented as written fully and timely.	Noncompliance

Recommendations:

1. Given that the statewide policy was disseminated more than a year ago, edits may already be needed (E1).

2. Update or develop facility-specific QA policy (E1).

3. The data list inventory needs improvement as described in E1, including ensuring its validity and completeness (E1).
4. The QA plan narrative could be improved by describing how the most important key indicators for each discipline are determined (E1).
5. The QA matrix needs improvement as described in E1 (E1).
6. Report on implementation of the items in the QA matrix (E1).
7. Address the recommendations regarding self-monitoring tools that are in E1, including the validity of the content, instructions, implementation, and review of results (E1).
8. Follow-up when needed on items raised in the individual and family/LAR satisfaction surveys (E1).
9. The QA report (and QAQI Council presentations) should include, when appropriate, information regarding program areas, living units, work shifts, etc., as per the wording of this provision (E2).
10. Resolve questions regarding the PIT meetings (E2).
11. Expand CAPs, as appropriate, beyond only the nursing department (E2).
12. Indicate how, when, and to whom the CAPs are disseminated (E3).
13. Implement, track implementation, and determine status/progress of CAPs (E4).
14. Evaluate the effectiveness of CAPs and, when necessary, make changes and implement the changes (E5).

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy #004.1: Individual Support Plan Process o DADS Policy #051: High Risk Determinations o Curriculum used to train staff on the ISP process o MSSLC Section F Presentation Book o MSSLC Self-Assessment o The last 10 section F monitoring tools completed by the QDDP Coordinator o List of all QDDPs and assigned caseload o A list of QDDPs deemed competent in meeting facilitation (26) o Data summary report on assessments submitted prior to annual ISP meetings o Data summary report on team member participation at annual meetings. o List of ISP meetings that occurred or were file over 30 days after the annual date. o A list of all individuals at the facility with the most recent ISP meeting date, date of previous ISP meeting, and date ISP was filed. o Draft ISPs and Assessments for Individual #398 and Individual #278. o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms/Action Plans, Monthly Reviews: • Individual #120, Individual #535, Individual #101, Individual #98, Individual #475, Individual #360, Individual #449, Individual #424, Individual #161, Individual #169, Individual #560, Individual #43, Individual #492, and Individual #504. <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 Kim Williams, QDDP Director o Carla Wilkins, QDDP Educator/Compliance Officer o Don Morton, Assistant Director of Programs o Joy Lovelace, Human Rights Officer <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 6/3/13 and 6/5/13 o ISP preparation meeting for Individual #589 o Annual IDT Meeting for Individual #278 and Individual #398 o Longhorn Unit Meeting 6/4/13 o QDDP Coordinator Meeting

	Facility Self-Assessment: MSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 5/17/13 with recent activities and assessment outcomes. The QDDP Director 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 Assistant Director, and QDDP Educator, as well as other activities for each provision. The facility was also observing ISP meetings, reviewing completed ISPs, tracking attendance at team meetings, and tracking completion and submission of assessments prior to the annual ISP meeting. For example, for F1b in regards to team participation in developing the ISP, data were gathered from the Settlement Agreement Monitoring Tools and meeting attendance was compared with information recorded on the Preferences and Strength Inventory regarding designation of relevant team members. These are the same type of activities that the monitoring team looks at to assess compliance. The facility had developed action steps to address deficiencies noted on the self-assessment. This should ensure that progress will continue to be made on developing an adequate ISP process. 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 Since the last monitoring visit, MSSLC IDTs had implemented the new ISP and risk identification process. Additional action taken to address the requirements of section F included: • A new data tracking system was implemented to track the submission of assessments prior to the annual ISP meeting. • Department leads began addressing the late submission of assessments. • Mentors from the QDDP department began attending more ISP and pre-ISP meetings to assist teams with the risk identification process. • A monitoring tool/checklist was created to assist the ISP Facilitators and QDDPs in covering all key topic areas during the ISP discussion. • Mentoring and assistance were provided to QDDPs following the annual meetings to ensure written plans were thorough and distributed timely. • Additional training on the ISP process had been provided to QDDPs. • The QDDP Director, QDDP Assistant Director, and QDDP Educator were completing a monthly sample of Settlement Agreement Monitoring Tools to assess compliance with the requirements of section F.

	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 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. Since a majority of individuals had not had an ISP developed in the new format, the monitoring team concentrated on providing comments regarding areas of improvement and areas that continue to need improvement from the limited sample available rather than offering compliance data in most areas. Compliance will be contingent on both the new plans meeting the requirements, and a sufficient number of individuals having plans that meet the Settlement Agreement requirements. There was positive progress evident with the new ISP process. At three ISP meetings and two pre-ISP meetings observed by the monitoring team, it was noted that significant progress had been made towards integrating the risk identification process into the ISP process. Rather than being two separate discussions held within the same meeting, the risk discussion was to some degree woven into the discussion regarding the individual's preferences, daily schedule, and support needs. Each IDT was in a different stage of integration, but all were moving in a positive direction. To move forward, • All departments need to ensure that assessments are completed at least 10 days prior to the annual IDT meeting and available to all team members for review. • IDTs need to ensure that deadlines are set and responsibility assigned when additional assessments are recommended by the team. Barriers to implementing recommendations in a timely manner need to be addressed • All team members need to ensure that supports are monitored for consistent implementation and adequacy. Data collected during monitoring should be used to revise supports when there is regression or lack of progress. The new process, thus far, was not resulting in adequate supports and measurable outcomes in many cases. Though considerable progress was noted, the facility was not yet in compliance with any of the provisions of section F.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed three ISP meetings in the new format. The QDDP facilitator facilitated the meetings. All meetings were good examples of facilitation that ensured that team members participated in the meeting and all topics were covered. Progress continued to occur and was evident, with regard to the facilitation of meetings. The facility used the statewide Q Construction Facilitation Training in conjunction with a competency tool used to assess competency in facilitation skills. Twenty-six QDDPs had been deemed competent in regards to facilitation skills. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was used to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QDDPs used this template to draft portions of the ISP prior to the meeting. The QDDPs 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. A sample of IDT attendance sheets was reviewed for presence of the QDDP at the annual IDT meeting. QDDPs were in attendance at all annual meetings in the sample reviewed. Good progress had been made towards developing an ISP that integrated all identified supports and services and focused on the individual's strengths and preferences. As noted throughout many sections of this report, the facility needs to focus on monitoring progress or regression and revising supports and services when needed. The assigned QDDPs remained responsible for monitoring and revision of the ISP. As noted throughout this report, the monitoring team found the QDDPs did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed. The facility did not have an adequate monthly review process in place to ensure that plans were updated when regression or lack of progress towards outcomes was noted.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>F1b</td><td>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.</td><td>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 pre-ISP meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Preferences and Strength Inventory (PSI) was the document that should identify the individual's preferences, strengths, and needs. This information should assist the IDT in determining key team members. MSSLC was using the PSI process to identify assessments to be completed prior to the annual ISP meeting and team members that should be present at the annual ISP meeting.

The facility was tracking data on attendance at IDT meetings. Data indicated good presence and participation by most relevant team members. Detailed data were reviewed for assessment submission for 39 annual ISPs meetings held during February 2013. The chart below indicates findings from that review.

<table><tr><td>All team members present</td><td>85%</td></tr><tr><td>Individual</td><td>97%</td></tr><tr><td>LAR/Family</td><td>100%</td></tr><tr><td>QDDP</td><td>100%</td></tr><tr><td>Psychologist</td><td>100%</td></tr><tr><td>Nursing</td><td>100%</td></tr><tr><td>OT</td><td>97%</td></tr><tr><td>PT</td><td>97%</td></tr><tr><td>Speech</td><td>77%</td></tr><tr><td>CLOIP/LA</td><td>92%</td></tr><tr><td>Nutrition</td><td>67%</td></tr><tr><td>Psychiatry</td><td>100%</td></tr><tr><td>Vocational</td><td>100%</td></tr><tr><td>DSP</td><td>95%</td></tr></table>
In some cases, it was not evident that the team had correctly identified all relevant team members. For example,
The required team member checklist completed at the pre-ISP meeting for Individual #161, did not identify his PCP, nutritionist, and dental staff though he had significant support needs in each area.
The required team member checklist completed at the pre-ISP meeting for Individual #98 did not include his PCP, psychiatrist, psychologist, nutritionist, or vocational staff. He had complex support needs that should have required input from those disciplines.</td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Review of a sample of ISP attendance sheets confirmed there was key staff missing at five of 10 (50%) of the annual meetings in the sample. For example,
At the annual ISP meeting for Individual #161, there was no participation by his DSP, dietician, PCP, or dental staff.
At the annual ISP meeting for Individual #98, there was no participation by his nutritionist or his psychiatrist.
Individual #120 did not attend her annual ISP meeting.
The facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process.</td><td></td></tr>
<tr><td>F1c</td><td>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.</td><td>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 gathered data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of assessments from 12/1/12 through 5/31/13 indicated that assessments were not routinely submitted prior to ISP planning meetings.

Detailed data were reviewed for assessment submission for 39 annual ISPs meetings held during February 2013. The chart below indicates findings from that review.

<table>
<tr><th>Assessment</th><th>On Time Submission</th><th>Late Submission</th><th>Not submitted</th></tr>
<tr><td>Medical</td><td>25/64%</td><td>10/26%</td><td>4/10%</td></tr>
<tr><td>Nursing</td><td>19/48%</td><td>10/26%</td><td>10/26%</td></tr>
<tr><td>Dental</td><td>33/87%</td><td>3/8%</td><td>3/8%</td></tr>
<tr><td>OT/PT</td><td>7/18%</td><td>20/51%</td><td>6/15%</td></tr>
<tr><td>Speech</td><td>7/18%</td><td>12/31%</td><td>8/21%</td></tr>
<tr><td>Nutrition</td><td>20/51%</td><td>19/49%</td><td>0</td></tr>
<tr><td>Psychology (of 28 requested)</td><td>11/39%</td><td>4/14%</td><td>14/50%</td></tr>
<tr><td>Psychiatry (of 16 requested)</td><td>10/63%</td><td>3/19%</td><td>3/19%</td></tr>
<tr><td>FSA</td><td>16/41%</td><td>19/49%</td><td>4/10%</td></tr>
<tr><td>Vocational (of 19 requested)</td><td>7/37%</td><td>12/63%</td><td></td></tr>
</table>
Newer ISPs supported the facility's determination that assessments were not being submitted prior to annual ISP meetings in some cases. Seven (70%) of 10 individuals had all assessment recommended in the PSI completed at least 10 days prior to the annual IDT meeting.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		• An OT/PT assessment was not completed for Individual #120 prior to her annual ISP meeting. Recommendations from her prior annual assessment included an annual re-assessment. Her PSI identified the need for both an OT and PT assessment. • A functional skills assessment and psychological assessment were not completed for Individual #449 prior to his annual ISP meeting. Both were recommended by the IDT according to his PSI. • For Individual #360, his functional skills assessment and vocational assessment were not updated prior to his annual ISP meeting as recommended in his PSI. The facility needs to continue to expand opportunities for individuals to experience new activities and record responses to those activities in order to identify a broader range of preferences. Those preferences should then be used to develop new skill acquisition opportunities. The facility continued to utilize the Functional Skill Assessment (FSA) to identify priority training. As noted in previous reports and in section S of this report, the FSA was not adequate for capturing this information. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT meeting to facilitate adequate planning. Assessments should result in recommendations for support needs when applicable. The facility was not yet in compliance with this item based on the 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 not consistently done in time for IDT members to review each other's assessments prior to the ISP meeting. There had, however, been considerable progress made in integrating assessment recommendations into support plans when available to the team. 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. Examples where assessment results were not incorporated into the supports and services developed by the IDT included: • Individual #169's ISP included outcomes referencing wheelchair positioning, use of a gait belt, mobility skills, and enteral feeding. His ISP noted that he did not	Noncompliance

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		have mealtime or mobility support needs. His OT/PT assessment also noted no supports were needed for mobility or mealtime. • Individual #475's Preferences and Strengths Inventory indicated that he did not like his job folding towels at the facility. He stated that he would like a housekeeping job. The team acknowledged his preference and noted that the vocational trainer would explore other options. Vocational outcomes to support his preferences were not developed. • Individual #504's Functional Skills Assessment indicated that he needed training in the area of domestic skills. The IDT did not develop training outcomes to address his skill deficits.	
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 mandated that a Living Options discussion 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. As part of the new ISP process, each discipline was asked to include as part of the pre-ISP assessment process a determination on whether or not needed supports could be provided in a less restrictive setting. Discussion by IDT members regarding community placement included preferences of the individual, LAR (if applicable), and family members, along with, opinions offered by each discipline. Any barriers to community placement were to be addressed in the ISP. At annual ISPs observed for Individual #278 and Individual #398, team members discussed providing supports in a less restrictive environment. Neither discussion was adequate for determining what barriers there were to supports being provided in the community and how the team would address those barriers. • For Individual #278, the QDDP asked for input from his brother and each discipline present at the meeting. Each person stated his or her opinion, though the team stopped short of developing a list of barriers and developing a plan to address those barriers. His brother discussed concerns regarding community living. The team did not adequately address his concerns or offer to provide additional information regarding community placement options. • Individual #398 expressed his desire to live in the community. The QDDP stated that a determination could not be reached regarding community living until a "high risk" assessment was completed. The team did not set a date to complete the assessment. The QDDP indicated that the team would discuss community placement "next year."	Noncompliance

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		Ten ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #475, Individual #169, Individual #43, Individual #560, Individual #161, Individual #504, Individual #98, Individual #120, Individual #449, and Individual #535. None (0%) of the ISPs included meaningful training opportunities in the community. Community based outcomes in the sample consisted of generic opportunities to visit in the community with little or no opportunity for training. For example: • Individual #161 had one outcome to be implemented in the community. The outcomes stated that he "will be given the opportunity to attend community events that he enjoys." • Individual #98 had three community based outcomes that stated he will be given the opportunity to attend community events/church/parks. There was no plan for specific training in the community. • Individual #449 had one community outcome that stated "home staff will accompany him to church services and events." When outings are planned specifically for greater exposure to the community, documentation should include a means to capture individual's preferences and interests. Those preferences and interest should be used to develop additional action steps that would encourage greater independence and integration into the community. Outcomes should be developed to address communication skills, decision making skills, social interaction, work and volunteer opportunities, and increased exposure to life outside of the facility. The facility was not in substantial compliance.	
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:		

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	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. It will be necessary for all assessments to be completed prior to the annual ISP meeting to ensure the team will have information necessary to determine prioritized needs, preferences, strengths, and barriers. In the ISP meetings observed, IDTs were having a much better discussion of support needs in relation to preferences. This was particularly evident in the risk identification discussion and the resulting discussion to develop supports needed to address identified risks. Lists of preferences included a much broader range of activities and were individual specific. IDTs were still not developing action plans that would expand on those preferences by providing opportunities to explore new activities, particularly in the community. As noted in F1e, additional opportunities to try new things should lead to the identification of additional preferences. ISPs in the sample provided few opportunities to gain exposure to new activities and learn new skills. As noted in F1e, a majority of plans in the sample offered individuals opportunities to visit in the community, but stopped short of offering opportunities for true integration, such as attending church in the community, banking in the community, joining community groups focused on her interests, or exploring volunteer or work opportunities. In a review of 10 recent ISPs, none (0%) offered specific training to be provided in the community. While the community was often listed as a possible training site for a outcomes, training was not designed specifically for functional training in the community. For example, Individual #120 had a money management outcome to identify a penny and nickel based on her preference for purchasing snacks. The SAP required her to identify a penny or nickel by name with training steps better suited for sitting at a table learning to identify coins. A compatible functional community outcome might have been handing the cashier money for snacks purchased in the community. For many of these individuals, community awareness and participation had been identified as obstacles to living in the most integrated setting, but IDTs did little to	Noncompliance

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		develop community integration strategies that would address these obstacles, including use of community settings to teach skills that would support successful community living or integrate preferences identified by and for the individual into SAPs.	
	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, however, there had been considerable progress made at the ISPs observed in IDTs considering what supports would be needed to successfully implement action steps developed by the IDT. A sample of ISPs and skill acquisition plans (SAP) were reviewed to determine if IDTs were developing individualized, observable, and/or measurable goals that included strategies and supports to ensure consistent implementation and monitoring for progress. The monitoring team found that there were still many outcomes not written in a way that staff could measure progress towards completion or did not provide enough information to ensure consistent implementation. For example: • Individual #160 had an outcome that stated, "PT activity walking plan to maintain walking skills." There were no staff directions for implementation. • Individual #424 had an outcome to live in the most integrated setting consistent with his preferences, strengths, and needs. An action step to achieving this outcome was to earn routine level of supervision. There was no criterion listed to determine when he would successfully complete this action step. Another outcome was to work on "his independence skills." Again, there was no criterion for successful completion of the outcome. • Individual #43 had a SAP to "to participate in a leisure activity to improve his community leisure skills independently in 88% of the monthly test trials." The teaching methodology did not provide clear instructions for consistently implementing the outcomes and measuring progress. • Individual #475 had the outcome "to attend trips to Wal-Mart and Krispy Chicken in Mexia." There was no clear behavioral criterion to measure success or completion. Outcomes under this general outcome included "have the opportunity to play and watch sports." There was no clear relation between the two outcomes. Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. Section M and section I also address the writing of measurable strategies to address health care risks. Section T elaborates on the facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs.	Noncompliance

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	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. It was designed to assist teams in more comprehensively planning for, discussing, and developing ISPs that addressed the individual's array of needs for protections, supports, and services, while approaching this in a person-centered manner and incorporating individuals' preferences and strengths. The development of action plans that integrated all services and supports was still an area with which the facility struggled. At both ISP meetings observed, the team spent more time than before trying to identify areas where measurable outcomes were needed. The teams also engaged in more integrated discussion regarding support needs in relation to preferences, though still struggled with developing integrated outcomes. 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. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings. The revised ISP meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and integrated health care plans. All plans were now considered a part of the ISP, however, teams stopped short of developing integrated outcomes in most cases. For example, the outcome section of the ISP for Individual #449 included an outcome for each recommendation in the behavioral assessment. Some of the outcomes could have been used as strategies for training in relation to outcomes based on his preferences. He had opportunities to participate in activities based on his preferences, but the outcomes did not include functional training. Combining his outcome for positive social interaction and his outcome to attend church events would result in functional training based on his preferences that would address barriers to his living in a less restrictive setting. Twenty of the 20 individual records requested by the monitoring team for section M of this report had a current Individual Support Plan (ISP). None of these ISPs, however, had sufficiently integrated the individual's health problems, needs and risks into the overall annual plan. The plans were also absent of how the individual participated in his own health care. For example, Individual #593 was noted to have polypharmacy with a diagnosis of GERD. Recorded in the ISP was that he loved most foods, but described him as having low mood, loss in appetite, and polypharmacy. The ISP did not contain	Noncompliance

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		information as how polypharmacy impacted his day to day life. 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. It is expected that progress will continue to be made in developing comprehensive plans as IDT become more familiar with the new ISP process and more adept at developing measurable outcomes.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	<u>Method for implementation</u> As discussed in F2a2, action steps in the sample of ISPs reviewed did not include clear methodology for implementation in some cases. Without clear instructions for staff, it would be difficult to ensure consistent implementation and determine when progress or regression occurred. Teams will need to develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. IHCP action steps were generally brief statements of action to address the risk. Most did not include methodology. For example: • Individual #98 had an action step to address his risk for dental that stated "encourage to keep dental appointments." There were no strategies developed to encourage him to attend appointments. An outcome to address his risk for cardiac disease stated "monitor blood pressure." The plan did not include an acceptable range for his blood pressure or action that should be taken if his blood pressure did not remain in a safe range (e.g., notify the physician if it was not within a stated range.) • Individual #101 had an action step to monitor lab values. The IHCP did not specify which lab values should be monitored. • To address his risk for weight gain, Individual #492 had an action step "to weigh every month and as needed." The plan should have included a range of weight gain or weight loss and what action would be taken if identified. (e.g., notify the dietician if weight increases by five pounds in a month) <u>Time frame for completion</u> Outcomes in the sample reviewed generally included a completion date of 12 months after implementation began. Completion dates should be assigned with a realistic expectation of when the outcome may be completed based on each individual's rate of learning. For outcomes that require staff to complete action, the team should set completion dates that ensure any barriers to supports are addressed as soon as possible.	Noncompliance

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		Examples where this did not occur included: • Individual #560 had an outcome to spend more time with his family. The team identified the need for the family to complete chaperone training. The completion date was 11 months after his ISP meeting. The team should have assigned a sooner date to have this completed to remove any barriers for him to complete his outcome. • Individual #398 expressed his desire to live in the community. A determination could not be reached regarding community living until a "high risk" assessment was completed. The team did not set a date to complete the assessment. • Individual #424 had an outcome to seek employment on MSSLC campus. The completion date was within a year. There were not action steps developed with assigned completion dates to ensure that supports needed to seek employment were provided in a timely manner. <u>Staff responsible</u> All SAPs and IHCPs in the sample included designation of which staff would be responsible for implementation of the outcome and which staff would monitor the plan. The facility was not in compliance with the requirement for identifying methods for implementation and time frames for completion.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The new ISP format provided prompts to assist the IDT in considering a wider range of supports and services when developing the ISP. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As noted in previous reports, many of the outcomes in the ISPs reviewed were functional at the facility, but often were not practical or functional in the community and did not allow for individuals to gain independence. During the week of the monitoring team's visit, some individuals reported that they had lost opportunities for independence due to transition into new homes determined to be more appropriate by facility management. For example, one individual was upset because he was moved to a new home where he was no longer allowed to wash his own clothing or semi-independently take his medication. Staff reportedly told him that was not the way they did things at that particular home. In another instance, an individual that was able to toilet independently was found wearing a diaper because others in the home required more support for toileting skills. None of the ISPs in the sample included outcomes for functional participation or integration in the community. For example, there were no outcomes to shop in the community for food to prepare a meal, complete transactions at a community bank, pick	Noncompliance

#	Provision	Assessment of Status	Compliance
		up prescriptions at the pharmacy, seek membership at a gym or library, or take a community art or fitness class. Outcomes were not developed to provide training on domestic skills, such as food preparation, housecleaning, or laundry care that would be necessary to live more independently in the community. Vocational skills were often taught in relation to jobs at the facility, but would not necessarily translate well in a community work environment. For example, individuals at the facility had part-time schedules for work or day activities. Lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch to eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community. IDTs will need to accurately identify needed supports and services needed to gain independence and function in a less restrictive setting through an adequate assessment process and then include those needed supports in a comprehensive plan that is functional across settings.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	DADS Policy 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. The new ISP format included columns for person responsible for implementation, type of documentation, and person responsible for reviewing progress. Integrated Healthcare Plans included similar information. The frequency of implementation was found on the SAP, IHCP, or on the ISP outcome summary. As noted throughout F2a, IDTs were still struggling with developing measurable outcomes with methods that would allow for consistent data collection to permit the objective analysis of progress. SAPs, ISP outcome summaries, and IHCPs included the person responsible for data collection and the person responsible for review of that data. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		nutritional indicators.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	This provision 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 F1, 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 available to all members of the IDT and integrated throughout the ISP.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in 22 out of 22 (100%) records reviewed. The facility reported that 59 (49%) of 121 ISPs were filed more than 30 days after the annual ISP meeting from January 2013 through May 2013. The facility needs to ensure that plans are distributed and available to staff implementing the plan within 30 days of development. As the state continues to provide technical assistance in ISP development, a strong focus needs to be placed on ensuring that plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support 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	Teams were required to meet to review any incidents, significant injuries, or changes in status immediately when determined necessary. Each discipline was assigned responsibility for reviewing specific services and supports in the ISP. QDDPs were responsible for reviewing the overall plan. There was a QDDP monthly review process in place to review supports. It was not evident that all services and supports were reviewed monthly or that the review of supports and services led to timely implementation of assessments or changes in supports when necessary. A sample of QDDP monthly reviews was reviewed for Individual #504, Individual #492, Individual #449, Individual #169, Individual #161, and Individual #360. An adequate review process was not in place for any (0%) of the ISPs in the sample. For example, • The March 2013 monthly review of services for Individual #449 was not completed until 5/4/13. His four vocational outcomes showed 0% response for the past two months. The QDDP did not comment on the lack of progress or make any recommendations. The review indicated no data available for outcomes in his BSP. Again, no comments or recommendations were made.	Noncompliance

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	ISP needs to be modified, and shall modify the ISP, as appropriate.	There was a section of the review form for a summary of risk action plan monitoring. The QDDP listed the risk levels for each category rated as high or medium, but did not comment on the efficacy of the action plan. The review indicated that he had a serious injury during the month reviewed. The QDDP did not comment on any change of supports or progress towards recovery. • The QDDP monthly review for Individual #492 dated 5/3/13 did not include an adequate review of supports and services. The section of the form for review of health care plans listed plans in place, but did not include data gathered for the review period. There was no review to ensure that action steps addressing his health care risk were being implemented. The section to review his PNMP was completed with "yes." Five SAPs were reviewed for progress. Progress for each outcome was noted as 0%. There was no specific summary of progress. The QDDP recommended "continue training" for each outcome. His monthly review dated 3/21/13 showed a similar lack of detail regarding progress and efficacy of supports. The section of the review to note community placement or transfers noted that he was not recommended for community placement or transfer. An ISPA held to discuss placement indicated that he had been referred for transfer to another SSLC on 1/8/13. • The QDDP monthly reviews for Individual #169 showed no data available for two of his BSP outcomes for March, April, and May 2013. He showed 0% progress on two of his vocational outcomes for the same three month period with no comments regarding barriers to achieving his outcomes. All outcomes were to be continued without modification. As the facility continues to progress toward developing person-centered plans for all individuals at the facility, QDDPs need to keep in mind that ISPs should be a working document that will guide staff in providing supports to individuals with changing needs. Plans should be updated and modified as individuals gain skills or experience regression in any area. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall	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. The facility had been trained by the state office on developing and implementing the ISP. QDDPs were still learning to use the new statewide ISP format. As noted throughout section F, adequate plans had not yet been developed for a majority of the individuals at MSSLC.	Noncompliance

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	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	The facility was documenting staff training on individualized specific plans, but as noted throughout section F, staff instructions for many plans did not offer enough information to ensure consistent implementation. Informal interviews throughout the facility indicated that staff were generally able to describe supports and services developed through the ISP process and plans were readily available for reference. This was an improvement from findings during the last review.	
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 ISPs were available in 22 (100%) of 22 individual notebooks in the sample. Informal interviews with staff indicated that not all staff were familiar with the requirements of individual ISPs. Data provided by the facility reported that 59 of 121 (49%) of ISPs were filed more than 30 days after the annual ISP was held. The facility needs to ensure that plans are distributed and available to staff implementing the plan as soon as possible, but no more than 30 days after development.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility 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 assurance activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility had just begun to analyze findings and develop corrective action plans based on self-assessment findings.	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. The facility needs to develop an adequate monthly review system so that plans can be monitored and revised as needed (F1a, F2d).

3. 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, F2a3).

4. The facility needs to expand opportunities for individual's to experience new activities and record responses to those activities in order to identify a broader range of preferences. Those preferences should then be used to develop new skill acquisition opportunities (F1c).

5. A description of each person's day along with needed supports identified by assessment should be included in ISPs. All supports and services should be integrated into one comprehensive plan (F1d).

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

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

8. IDTs 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. 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, F2f).

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

13. 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).

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

15. Develop a monthly review system adequate for determining the efficacy of all supports and services. 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).

16. 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).

17. 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 MSSLC Draft Policy Minimum Common Elements of Clinical Care 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, 2013 Interviews and Meetings Held: o Christopher Ellis, MD, Medical Director 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 three activities, all of which focused on meeting attendance, The clinical services meeting and ISP attendance rates were reported. Additionally, the third metric captured the attendance of medical providers at ISPs where the PCP was requested to attend. As noted in previous reviews, the integration of clinical services cannot be measured by meeting attendance alone. 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 provision G1 and in substantial compliance with provision G2. The monitoring team found the facility in noncompliance with both provision items.
	Summary of Monitor's Assessment: There was no significant progress noted in this area. MSSLC had not implemented any facility initiative that was intended to specifically foster integration among the clinical disciplines. Nonetheless, the monitoring team did find integration occurring in several areas. The policy related to the minimum common elements of clinical care was submitted to QAQI Council for approval. This policy did not adequately address Provision G. The monitoring team had the opportunity to meet with the medical director to discuss integration activities at the facility. This discussion focused on some of the activities that were occurring as well as the next steps that should be taken to move towards substantial compliance. Throughout the week of the review, the monitoring team encountered a few good examples of integrated clinical services. There were many other opportunities to improve integration of clinical services that were being missed.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The medical director served as the lead for this provision. Given his recent transition into the position and the many areas that required attention, this provision had not been a primary focus. Therefore, there was little change in this area since the previous compliance review. A local policy Minimum Common Elements of Clinical care was drafted and presented to QAQI Council for approval. This policy detailed issues related to Provision H, but also included a section on integration of clinical services that listed the various multidisciplinary committees that functioned at the facility. The monitoring team met with the medical director to discuss integration of clinical services at MSSLC. The evidence presented for this section was essentially limited to the attendance of the various disciplines at ISPs and clinical services meetings for the first two months of 2013. The monitoring team was interested in learning more about the actual services that occurred and how integration helped to deliver those services. The medical director described several activities, such as the collaboration between dental and nursing to provide suction toothbrushing. 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, the monitoring	Noncompliance

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		team observed integration in daily meetings, committee meetings and in the actual delivery of services: The monitoring team attended the following daily meetings: • Daily Clinical Services Meeting – This meeting occurred every morning at the beginning of the workday. Participants included the medical director, all PCPs, psychiatrists, chief nursing executive, clinical pharmacist, dental director, and the psychology director. The events of the past 24 hours were discussed, including hospital admissions, transfers, use of emergency drugs, medication and clinic refusals, and restraints. • Daily Unit Meetings – Each of the five units held a meeting each morning of unit administration, QDDPs, and some clinical staff. It was another forum for discussion of events of the past 24 hours. Committee meetings attended by the monitoring team included: • Pharmacy and Therapeutics Committee • Medication Variance Reduction Committee • Polypharmacy Oversight Committee • Desensitization Committee • Weekly Medical Review Committee Details related to the function and activities of these committees are provided throughout this report. Efforts to improve integration of clinical services was observed among the various clinical disciplines: • Medical o Medical, pharmacy, and nursing collaborated to resolve issues related to medication timing. o Medical collaborated with psychiatry and pharmacy to review the medication regimens of individuals receiving anesthesia off campus. • Dental o The dental director and the LVN responsible for suction toothbrushing were conducting training and monitoring on the home to help improve oral care in the homes. o The dental clinic collaborated with education and training staff to write SAPs for toothbrushing. o The dental clinic continued its daily summary that included failed appointments. This information was forwarded the unit directors for discussion during the next day's unit meetings.	

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		o The dental director worked with medical and psychology via the desensitization committee to remove barriers to dental treatment. During the meeting observed by the monitoring team, the clinical disciplines had good discussions that produced actionable steps such as trying another provider or obtaining a consult from another discipline. • Pharmacy - The pharmacy department was working with habilitation services to ensure medications were delivered in the proper texture. • Habilitation Services - The PNMT worked well together in an integrated manner for assessment and the development of intervention plans in conjunction with the IDTs. Many of the referrals to the PNMT were generated by the IDTs rather than self-generated. • Psychology - Psychologists and psychiatrists appeared to have meaningful interactions during psychiatric clinic meetings. During the onsite review, the monitoring team attended the ISP for Individual #398. The meeting was well attended and all relevant clinical services were represented at the meeting. The integrated risk rating form and integrated health care plan were completed during this meeting. The IDT reviewed each risk separately. The RN Case Manager was familiar with the individual's history, and shared information about the individual's eating history. The team had a lengthy discussion related to the assignment of risk. This observation was most likely the "tip of the iceberg," as clearly the identification and determination of risk, was both challenging and problematic for the teams. It was evident the team will need support and training in assessing and assigning risk objectively. The monitoring team also noted several areas in which there was a definite lack of integration: • The medical staff continued to have dismal participation in the annual ISPs. The data provided to the monitoring team indicated that the primary medical provider attended only 17% of the annual ISPs for the reported period. • The medical staff did not attend PNMT meetings. A system of the PCP attending during specific discussion about an individual on their caseload may be a good approach to provide integrated supports and services in a timely manner. Needs were identified during the meeting and the physician would be able to initiate orders and other directives to ensure timely implementation. • While information about various topics (i.e., polypharmacy, individuals with epilepsy) were discussed with the IDT, it was not always possible to determine the integration of that information in the treatment plan provided for the individual. The integration with regard to the IDT process evident in psychiatry clinic was better spelled out in the psychiatric quarterly evaluations due to	

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		various disciplines providing pertinent information for the integrated document (i.e., nursing, psychiatry, psychology, and pharmacy). • Neurology-psychiatry – The documentation reviewed by the monitoring team did not reflect adequate integration of neurology and psychiatry. Overall, the monitoring team saw evidence of integration, but much work was needed. Those areas that clearly needed to improve in integrating services have remained without change for some time and require attention.	
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 utilized the state database to track consults. A total of 45 consults completed after September 2012 (including those from the record sample for Section L) were reviewed: • 35 of 45 (78%) 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. Generally, the IPN documentation did not include any decision regarding referral to the IDT. The facility continued the use of the Providers Review of Recommendations Form. The form required the provider summarize the recommendations and state agreement or disagreement with the recommendations. Most forms also indicated if the matter required an IDT meeting. The medical director explained that this form was only completed when the primary provider intended to notify the IDT of changes in the individual's plan. It appeared that the forms were completed by some providers even when the provider did not believe the IDT needed to meet. Once completed, the form was taken to the morning unit meeting by the unit nurse. The execution of this procedure varied among providers. The monitoring team found very few examples of the forms. Similar to the previous compliance review, it was not clear if the forms were not present because there were no changes to communicate or if the form was not filed. The presentation book included a form for Individual #224. The PCP documented that no changes were recommended and no IDT meeting was required. Nonetheless, the form was presented at the unit meeting. The RN documented that the IDT agreed no meeting was necessary. Per state policy "If the recommendations are implemented, the PCP writes 'agreed' on the consultant report, signs and dates the notation, and then writes a corresponding	Noncompliance

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		progress note explaining the reason for the consultation, the significance of the results, and the orders." Documentation of a clear explanation in the IPN was required if the recommendations were not implemented. With regards to referral to the IDT, state policy stated, "The PCP or designee shares the consultation recommendations with the IDT, when applicable." The Settlement Agreement specifically requires "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." In order to meet the requirement of the Settlement Agreement the documentation must include a decision regarding IDT referral. This documentation should be present in the IPN entry because the actual referral and completion of the form is left to the discretion of the provider. This provision remains in noncompliance due to the inconsistent documentation of the matter of IDT referral.	

Recommendations:

1. The facility should proceed with development of a local policy that addresses the integration of clinical services. 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 review the current consultation documentation requirements and ensure that the current procedure meets all requirements (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 consults (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 Action Plan for Sections G and H o MSSLC Sections G and H Presentation Books o MSSLC Draft Policy Minimum Common Elements of Clinical Care 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, 2013 Interviews and Meetings Held: o Christopher Ellis, MD, Medical Director 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: 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 For Provision H1, the self-assessment reported compliance for completion of annual ISP assessments and quarterly assessments. The assessment indicated that 100% of the individuals records were reviewed from 12/1/12 to 3/30/13 to determine compliance with completion of quarterly assessments. This was an enormous task given the census of the facility. It was reported that 99% of the QDRRs were completed in a timely manner. The pharmacy department reported 70% for 10/1/13 - 3/30/13, which was the reporting period for this review. The reason for the differences in data was not clear. The quality of the assessments was not addressed in the self-assessment. There was also no metric to determine compliance with non-scheduled or acute assessments that would be done as a result of a change in status.

	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 should describe the types of audits/tools, 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. The data would be reported for a specified timeframe. 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 agreed.
	Summary of Monitor's Assessment: The facility made very little progress in this area. The medical director served as lead for this provision. A policy for the minimum common elements of clinical care was submitted to the QAQI Council for approval the week of the compliance review. MSSLC was tracking assessments, but this was limited to timelines only. There was no documentation provided relative to the quality of the assessments. There was no additional work done in the development of clinical indicators, but the proposed policy provided guidance on indicator selection and management. Much of this provision revolves around issues of quality and assessment of the quality of clinical care provided. As such, the development of a robust set of clinical indicators must be a priority in moving forward.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	There was no significant progress in this area apart from the development of a policy to guide the provision. This policy, which was based on guidelines in the state draft policy, required each department 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 discussions with the medical director, he explained the facility's plan for completion of required scheduled assessments. It was clear that a great deal of thought had gone into the approach that needed to occur to maximize compliance and best utilize the available resources. Efforts to improve this were ongoing.	Noncompliance

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		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: • Annual Medical Assessments - The monitoring team found no deficiencies for the 24 AMAs reviewed with regards to timelines. Overall, the quality was adequate, but improvement was needed in some areas, such as providing more detail for each plan associated with an active problem. Annual Medical Assessments are discussed further in section L1. • Quarterly Medical Assessments - Quarterly evaluations were found in 44% of the records reviewed. As discussed in section L1, this may have been the result of a record filing issue or other document request issues. • Quarterly Drug Regimen Reviews - The compliance for timely completion for the reporting period of months of October 2012 - to March 2013 was 70%. The QDRRs also needed additional work to improve the clinical relevance of the documents. • Comprehensive Annual Dental Assessments - The overall compliance score was 99%. The quality of the documents also improved. • Psychiatry - The facility reported 92% of the QPMRs were done within 90 days since the last visit and 95% of the Appendix B evaluations had been completed. Given that 241 individuals received psychiatric services, this was a large accomplishment. • Nursing - In a sample review of the most current quarterly and annuals, there were little improvements in the inclusion of a review of the individual's past and present health status and response to intervention including, but not limited to treatments and medications to achieve desired health outcomes. • Habilitation - The PNMT conducted assessments for individuals referred to the team. The assessments were now completed in a timely manner. These assessments resulted in a series of recommendations that required collaboration between the PNMT and the IDT to ensure integration of actions into the ISP for timely implementation. The documentation of completion of these and due dates with staff responsible was inconsistent. As such, it was difficult to determine if action steps were implemented in a timely manner. The OTPT and communication assessments were generally completed annually for individuals who were provided supports and services though a significant number were not completed in a timely manner, most often after the ISP. Only 29% of the communication assessments were considered on time and only 12% the OTPT assessments were submitted within 10 working days of the ISP.	

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		This provision remains in noncompliance. The facility did not have an adequate system in place for tracking the timeliness of assessments as well as the quality of the assessments. Achieving substantial compliance will require the facility to track scheduled and non-scheduled (acute) assessments across all clinical disciplines. Moreover, each discipline must monitor the quality of the assessments based on indicators that capture compliance with the acceptable standard of practice.	
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 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 and were consistent with the documented signs and symptoms of disease exhibited by the individuals. • Across the majority of Integrated Progress Notes reviewed, there were identified acute illness and injury. Nursing interventions included assessment of the complaint/problem, implementation of interventions, and the documentation of approved NANDA diagnosis on the Acute Care Plan and within the Nursing Assessments. • Over the course of the visit, the monitoring team observed that the IDT mostly addressed maladaptive behaviors instead of being knowledgeable about the psychiatric symptoms identified in order to establish the diagnosis. The IDT needed to develop combined case formulations in order to provide cohesive diagnostics consistent with the current version of the DSM and to implement an applicable treatment plan. The revision of diagnostics predominantly occurred during the QPMRs. This provision remains in noncompliance.	Noncompliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	During the September 2012 review, it was reported that a set of clinical indictors was developed a few weeks prior to the compliance review. The indicators included UTIs, osteoporosis, diabetes mellitus, aspiration pneumonia, constipation, and seizure disorder. No additional work had occurred in regards to the development of clinical indicators. However, a policy for Provision H outlined requirements for development of clinical indicators across all disciplines. This policy provided an extensive list of examples as well as the criteria for appropriate oversight. The minimum common elements of clinical care could be applied to many conditions. For example, in the management of osteoporosis, an individual at risk would have a medical assessment and workup that would include measurement of bone mineral density, calcium, and vitamin D levels. Following implementation of treatment, nursing would perform monitoring and general assessments. Physical therapy might develop	Noncompliance

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		exercise programs for select individuals. The nutrition department would provide data on calcium and vitamin D requirements. Habilitation services would ensure that the appropriate measures were taken for individuals who required lifts and transfers. They would train staff and periodically conduct monitoring. The primary provider would ensure that re-evaluations were done at the appropriate intervals to assess the effectiveness of treatment. Many of these activities were already occurring at the facility. MSSLC lacked a mechanism for assessing the activities that were taking place. The clinical indicators would be helpful in objectively determining if treatments and interventions were timely and clinically appropriate. They also provide a quantitative basis for quality improvement, or identifying incidents of care that trigger further investigation.	
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 already noted, the development of clinical indicators was pending approval of the policy developed to guide Section H. The local policy, consistent with the state draft policy, included a relatively long list of data for the facility to collect and monitor in areas of medical staffing, timeliness of actions, equipment and resources, quality of care severity indices, expected death rates, morbidity, clinical indicators for a variety of conditions, diabetes care, and patient satisfaction. It would also appear that in selecting these data elements that the facility was establishing the framework for a medical quality program. Additional measures of medical quality should be selected. A good starting point would be the six disease entities chosen by state office. For each condition, a number of specific and measurable metrics could be developed. Periodic auditing using these metrics would allow the facility to determine if treatments were clinically justified, appropriate, and timely. The monitoring team noted the following during the conduct of the compliance review: • The therapists were generally consistent with their documentation of direct therapy with IPNs only. Data sheets for treatment sessions, weekly summaries, and monthly reviews/reassessments to document progress toward established goals were not generally noted. A system for effectiveness monitoring was not clearly established. • Across all records reviewed, the clinical justifications for the goals/indicators of the efficacy of treatments were unclear. Little improvement was noted in moving away from goals that indicated that they would experience less untoward outcome(s) than they suffered over the past year, and most individuals had goals indicating they would not experience an untoward goal. It was evident the teams could benefit form more training and support regarding outcome identification, measurement, and evaluation. • Collaborative efforts took place between psychiatry and psychology in the	Noncompliance

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		psychology/psychiatry forum the week of the review. The clinicians discussed strategies of the two disciplines identifying similar clinical indicators for determination of treatment efficacy.	
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.	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 process implementation of the assessment and reporting protocols and performance of acute, quarterly, and annual assessments serve as such systems, there was no substantial evidence that it was satisfactorily implemented. Health Care Plans which were in place were not adequately reviewed/revised in accordance when identified changes occurred in their health status and risks. A system to effectively monitor the psychiatric health status of individuals involved the participation of numerous disciplines in the QPMRs. Nursing staff presented documented medical information for the psychiatry clinic. The psychiatrist had access to the physician's medical assessment in the record. The psychology representative reported data predominantly composed of information such as aggression to self/others, and unauthorized departure. The IDT had not worked out details of who was going to definitively collect and analyze data in relation to the monitoring of the psychiatric health status of those receiving psychotropic medication. Quarterly assessments for the medical and pharmacy departments had the ability to monitor long-term health status and chronic medical issues. The QDRRs were not completed in a timely manner and the QMSs were found in few records. Thus, two very good means of monitoring chronic health status were not completed as required. The need to link all of the current monitoring systems remained an important and outstanding one. Monitoring health status requires a number of processes, reviews, and evaluations due to the need to monitor both acute changes and chronic long-term disease. The monitoring team noted several components that would contribute to monitoring health status: • Risk assessment • Periodic assessments (medical, nursing, therapies, psychiatry, and pharmacy), • Acute assessments via sick call • Reports of acute changes via the daily clinical services meetings • Medical databases (preventive care, cancer screenings, seizure management) • The medical quality program would be the designated quality program and would report certain data elements to the QAQI council. Through the appropriate execution of these systems, an individual's care and monitoring	Noncompliance

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		could be assessed across this continuum of activities. 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 develop a set of clinical indictors 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.	
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 facility had not established a comprehensive set of indicators. Therefore, at the time of the review, the facility was not tracking changes in treatments and interventions based on signs and symptoms used as clinical indicators. Once clinical indicators are established, the medical director could conduct audits of acute care based on persons who were seen for sick call and individuals who required transfer for acute care. Reviews of chronic care could also be completed as part of the medical quality program. In the case of osteoporosis, clinical guidelines or protocols define the standards of treatment. Thus, following the implementation of the treatment outlined in H3, the medical provider would conduct reassessments such as bone mineral density, calcium, and Vitamin D levels to measure the response to treatment. Results of those diagnostics would assist in decisions regarding further treatment. The medical quality program would monitor the care provided to individuals for this chronic condition.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	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. The facility will need to determine how to monitor this.
    c. All assessments must meet an acceptable standard of practice and standardized tools should be used to objectively make this determination (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 new policy provides guidance for this process (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 individuals with serious injuries in the past year 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 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 constipation o List of individuals with a pica diagnosis 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 individuals with chronic pain. o List of individuals with challenging behaviors. 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 Draft ISPs and Assessments for Individual #398 and Individual #278. o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews: • Individual #120, Individual #535, Individual #101, Individual #98, Individual #475, Individual #360, Individual #449, Individual #424, Individual #161, Individual #169, Individual #560, Individual #43, Individual #492, Individual #506, Individual #492, Individual #13, Individual #641, and Individual #504.

	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 Kim Williams, QDDP Director o Carla Wilkins, QDDP Educator/Compliance Officer o Don Morton, Assistant Director of Programs o Gabby Brewer, Program Compliance Nurse o Norris Buchmeyer, Director of Nursing o Joy Lovelace, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 6/3/13 and 6/5/13 o ISP preparation meeting for Individual #589 o Annual IDT Meeting for Individual #278 and Individual #398 o Longhorn Unit Meeting 6/4/13
	Facility Self-Assessment: MSSLC submitted its self-assessment. Along with the self-assessment, the facility submitted an action plan that addressed progress towards meeting the requirements of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility planned to engage 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. The facility was using the Settlement Agreement Monitoring Tool to review a sample of Integrated Risk Rating Forms (IRRFs) monthly. Additional activities completed to assess compliance included a review of facility policies, the assessment tracking data, and employee training records. The facility recognized that the risk process was a very new process for the IDTs and it would take some time to develop an adequate system for addressing risks. 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 substantial compliance through an initial attempt to ensure 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. Since the last review, the state office had made revisions to the At-Risk Individuals policy. The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred since the last review. Risk screening was reviewed annually at the ISP planning meeting. There was still a tendency to over-rely on the guidelines for each risk category without factoring in how the various risk factors may compound one another. Good clinical judgment must be used when identifying risks, and developing risk levels, and action plans for high risk conditions. Revisions to the risk identification process 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. The monitoring team had a chance to observe two teams hold meetings utilizing the new format. Progress had been made towards integrating the risk discussion in relation to each individual's preferences, strengths, and daily schedule. The facility was moving in a positive direction, though additional training was still needed to help team develop meaningful plans through this process. 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 reviewing supports following a change in status, but failing to ensure that assessments were completed and recommendations were implemented. Plans should be implemented immediately when individuals are at risk for harm, and then monitored for efficacy.

#	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 related (regarding outcomes or provision of services and supports) were listed together, and linking each risk factor with specific clinical indicators.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In addition, the Integrated Risk Rating Form (IRRF) was revised to follow the same 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 monitoring team was able to observe three IDT meetings using the new style ISP format and new risk rating forms. Progress towards developing an effective process to identify risks was observed in all meetings. IDTs were utilizing the newly created IRRF and IHCP. At the ISP meetings observed for Individual #278 and #398, the team engaged in a much more integrated discussion regarding risk ratings and developing action plans to address risks. Assessment information was taken into consideration for each risk rating and the IDTs considered many relevant factors that contributed to each risk category. For example, in looking at Individual #398's risk for diabetes, the team not only considered his history, but also discussed his BMI (overweight) and side effects of medication. Overall, both IDTs made rational determinations on risk ratings based on information available. Individual #398's team did a nice job of integrating the risk discussion into the deliberation regarding his preferences, lifestyle, and support needs. Individual #278's IDT still conducted somewhat of a segmented risk discussion, then moved into discussion regarding his preferences and support needs. Further integration of the planning process will take additional mentoring and practice. In both ISP meetings, the IDTs stopped short of developing measurable goals and designating who would be responsible for monitoring and ensuring that supports were effective. While much progress had been made in the risk process, additional training is still needed to ensure that team members develop action plans that will reduce the chance of untoward outcomes. The state policy required that all relevant assessments be 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 to track submission of	

#	Provision	Assessment of Status	Compliance
		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. The facility had taken many positive steps towards ensuring that an adequate risk assessment process was implemented. The monitoring team looks forward to seeing continued progress in identifying risk and developing strategies for monitoring and minimizing those risks.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	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. Health risk ratings will need to be consistently revised when significant changes in individuals' health status and needs occurred. A sample of records was reviewed to determine if a determination of risk resulted in an assessment of current services and support, risk ratings, and/or plan revisions. It was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time when recommended. Due to the lack of revisions made to the IRRFs when individuals experienced a change in status or hospitalization, the monitoring team was unable to determine what additional assessments were needed and/or conducted in response to the change of status. IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. When recommendations for assessments were found on the Risk Action Plans, the date of completion was frequently stated as ongoing or as ordered. Thus, it was not possible to determine if recommendations from assessments were incorporated into supports and tracked for efficacy. For example, • Individual #161 had an action step to perform laboratory draws and monitor blood work in response to his risk for circulatory disease. A completion date and the results of lab work were not noted on the IHCP. His QDDP monthly review indicated that lab work was completed on 2/19/13 with no results known. His action plans for fall risks included assessing his home and work environments to assess safety concerns regarding falls. Again, there were no completion dates and no recommendations from the assessment noted on the IHCP. • Individual #169 was at medium risk for dental disease. His IHCP had an action step that stated, "attend scheduled dental appointments." A completion date and the results of dental assessments were not recorded on his IHCP. His QDDP monthly review noted a dental consultation during the month of March 2013,	Noncompliance

#	Provision	Assessment of Status	Compliance
		but did not summarize the findings. Integrated Risk Rating forms did not consistently include specific clinical data that should indicate that a change in status review was needed. Thus, the monitoring team was unable to determine if a change in status had occurred for most individuals in the sample unless a significant illness or injury was documented elsewhere in the record. There was no sense of urgency, even following a significant change in status, to ensure that supports were adequate to prevent a serious incident or illness. For example, • Individual #508's IDT met numerous times between 1/18/13 and 4/10/13 to review trends related to peer-to-peer aggression and injuries. Supports were not revised when not effective and action steps were not developed to attempt to prevent the likelihood of a serious injury due to peer-to-peer aggression. • Individual #449 sustained a serious injury to his wrist requiring surgery on 4/8/13. It was not evident that the team reviewed his risks or implemented additional supports following surgery. On 4/26/13, his IDT met to discuss an allegation of abuse. The team recommended an assessment by habilitation therapy for his wrist. There was no documentation that an assessment was completed. His risk assessment, IHCP, and PNMP were last updated in January 2013. IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. The process to ensure timely completion and implementation of action plans needs to be refined to meet substantial 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	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. 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. All ISPs in the sample included strategies to address identified risks, but again, not all assessments were submitted prior to the determination of risk ratings, thus, it was unlikely that risk ratings were based on current data. 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. As noted in section F, a comprehensive monthly review process was not yet in place to ensure that plans were being implemented and monitored as needed.	Noncompliance

#	Provision	Assessment of Status	Compliance
	ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	As noted in I2, IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. IDTs were not documenting when plans were implemented. Thus, it was not possible to determine if IDTs implemented all recommendations from assessments within 14 days. For example, Individual #98 sustained a fractured jaw as a result of peer-to-peer aggression. His risk assessment and IHCP were updated following the incident. He was placed on a liquid diet to reduce his risk of choking. On 4/1/13, the physician determined that he was possibly dehydrated and at risk for dehydration due to his restricted diet. He received a nutrition consultation resulting in a change of diet. His risk ratings and IHCP were not revised and it was not evident that the team met to ensure that recommended supports were implemented and monitored. Many of the risk action plans in the sample reviewed did not include specific risk indicators to be monitored for all areas of risk. Risk action plans often referred to an ancillary plan in place or instructions were too general (e.g., follow diet, follow PNMP). Not all ancillary plans were integrated into the ISP, so staff did not have a comprehensive plan to monitor all supports. It was not evident that clinical data were gathered and reviewed at least monthly for all risk areas.	

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 (I1).
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 List of all individuals with medical/dental desensitization plans and date of implementation 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); frequency of clinical contact (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, with dates of completion, and scores 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: 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 refused to authorize psychiatric treatments and/or medication recommendations o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend, including any information that is routinely collected concerning the psychiatrists' attendance at the IDT, ISP, ISPA, and BSP meetings o A list and copy of all forms used by the psychiatrists o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists o A list of all psychiatrists including board status; with indication who had been designated as the facility's lead psychiatrist o CVs of all psychiatrists who work in psychiatry, including any special training such as forensics, disabilities, etc. o Overview of psychiatrist's weekly schedule o Description of administrative support offered to the psychiatrists o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility o A list of continuing medical education activities attended by medical and psychiatry staff o A list of educational lectures and inservice training provided by psychiatrists and medical doctors to facility staff o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who have a diagnosis of seizure disorder o For the past six months, minutes from the committee that addresses polypharmacy o 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 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 A list of individuals requiring chemical restraint and/or protective supports in the last six months <u>Documents Requested Onsite:</u> o Copy of the section J presentation book o Most recent facility policy regarding psychiatric services o Human Rights Committee Policy and Procedure o Desensitization Committee Policy and Procedure o Minutes from the Desensitization Committee meeting 6/4/13 and the past nine months o Minutes from the psychology/psychiatry meeting 6/6/13 and the past nine months o Resume and Job Description regarding Angela Johnson, R.N., nurse compliance monitor, Section J o All data presented, doctor's orders, and Dr. Brown's documentation for psychiatry clinic 6/4/13 regarding Individual #161 o All data presented, doctor's orders, and Dr. Rao's documentation for psychiatry clinic 6/4/13 regarding Individual #331 o All data presented, doctor's orders, and Dr. Brown's documentation for psychiatry clinic 6/5/13 regarding Individual #455, and Individual #356 o All data presented, doctor's orders, and Dr. Kirby's documentation for psychiatry clinic 6/6/13 regarding Individual #475 o All psychiatry clinic notes per Dr. Kirby regarding Individual #595 for the past nine months o All data presented, doctor's orders, and Dr. Shet's documentation for psychiatry clinic 6/6/13 regarding Individual #243 o All psychiatry clinic notes per Dr. Shet for psychiatry clinic 6/6/13 regarding Individual #164 o These following documents for the individuals listed: Individual #466, Individual #589, Individual #243, Individual #595, Individual #164, Individual #331, Individual #161, Individual #475, Individual #848, Individual #990, Individual #195, Individual #994, Individual #142, Individual #455, and Individual #356 • Identifying data sheet • Social History (most current) • Annual Medical Summary and Physical Exam (most current) • Quarterly Medical Review • Health Management Plan (most current) • Hospital Section for the last six months • Active Current Diagnoses Sheet • X-ray/Lab section (for the last six months)

	• Annual Weight Graph • EKG section for the last year • Psychiatry section (for the last nine months) including Appendix B evaluation • Neurology section (for the past year) • Seizure Graph/Record (Active) for the last year • Quarterly Nursing Assessment (most current) • Nursing Reports for psychiatry clinic for the past six months • Psychology reports for psychiatry clinic for the past six months • Psychology Evaluation (most current) • QDDP notes for psychiatry clinic for the past six months • Safety Plan/Crises Plan • MOSES/DISCUS results (for the last six months) • Reiss Screen • Pharmacy section (for the last six months) inclusive of Pharmacy Quarterly Drug Regimen Reviews • Physician's Orders for the last six months • Current list of all medications (e.g., MAR) • Consent section for psychotropic medication • Consent section for pretreatment sedation • Integrated progress notes (for the last six months) • ISP, ISP addendums, and signature sheets (for the last nine months) • Behavior Support Plan • Desensitization Plan • Human Rights Committee Review of consent for psychotropic medication, pretreatment sedation, and BSP (most current) for the last six months • SOTP (most current) • High Risk Determination (if applicable) <u>Interviews and Meetings Held</u>: o Christopher Ellis, M.D., Medical Director o Kendall P. Brown, M.D., (Lead Psychiatrist), Christopher Ellis, M.D., Juanita F. Kirby, M.D., Madhu Rao, M.D., and Prakash Shet, M.D., M.B.A. o Angela Johnson, R.N., nurse compliance monitor, Section J o Psychiatry assistants: Ms. Virginia Jackson and Ms. Bobbie Hall o Charlotte M. Kimmel, Ph.D., Director of Psychology o Anyssa Garza, Ph.D., Pharmacy Director <u>Observations Conducted</u>: o Psychiatry clinic conducted by Juanita F. Kirby, M.D. o Psychiatry clinic conducted by Madhu Rao, M.D. o Psychiatry clinic conducted by Kendall P. Brown, M.D.

	o Psychiatry clinic conducted by Prakash Shet, M.D., M.B.A. 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 Polypharmacy Meeting o Human Rights Committee o Psychology/Psychiatry Meeting o Medical Review Committee
	Facility Self-Assessment: The psychiatry department had further developed what was presented last time by including a wider variety of activities in the self-assessment. Further, they were numbered and each activity had a corresponding listed item with the calculated results. In that regard, the psychiatry department made progress in identifying activities to monitor for determination of outcomes for each provision item. The monitoring team spoke at length about the self-assessment with members of the psychiatry department, including the medical director, during the onsite review. The self-assessment provided by MSSLC reflected some similarities of information gathered by the monitoring team. 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 self-assessment, however, also focused on the results of statewide self-monitoring tools. It was previously cited by the monitoring team that there were numerous 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 incorrect. 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 three provision items (J1, J2, J5). The monitoring team assigned ratings of substantial compliance for five provision items (J1, J2, J5, J6, J7). The activities and outcomes upon which the psychiatry staff self-rated each provision were not always pertinent to determine substantial compliance with the provision. Further, the activities the facility engaged in were not consistent with what the monitoring team evaluated. • 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 the physician's specialization in child and adolescent psychiatry, board status, and experience in regards to working with individuals with developmental disabilities. • Furthermore, pertinent up to date information, such as the availability of services by a child and adolescent psychiatrist at MSSLC, were not cited in the facility self-assessment. The monitoring discovered during the onsite visit that the facility actually utilized consultation by a child psychiatrist in the community setting, since the last review, in order to assist with the

development of a minor's treatment plan. This illustrated care by persons who are qualified professionals for the treatment of youth at MSSLC and was one of the main reasons of being assigned a rating of substantial compliance by the monitoring team. During the onsite visit, the psychiatry department agreed with the monitoring team's recommendation to cite such essential information in future self-assessments.

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 J2, the first activity listed by the facility was "reviewed records of psychiatrists providing services to ensure they are board-certified" or board eligible psychiatrists. The monitoring team did not review records in order to ensure the board status of a psychiatrist.

- Board eligibility and certification was determined by completion of training in an educational program, such as the Accreditation Council for Graduate Medical Education (ACGME). The ACGME is responsible for the accreditation of post-MD medical training programs within the United States. The psychiatrist would then apply for eligibility to take the respective board examination in order to receive certification in their specific specialty (i.e., child and adolescent psychiatry).
- On a positive note, the facility provided data to the monitoring team that reflected calculation of the number and percentage of the comprehensive psychiatric assessments that were completed for those individuals who were prescribed psychotropic medication. Upon further inquiry during the onsite visit, the facility also informed the monitoring team of the number and percentage of quarterly psychiatric evaluations completed but did not list such data in the J2 provision item to further support the conclusion of substantial compliance.

In regards to J6, of the 242 individuals enrolled in the psychiatry clinic, 229 received a comprehensive psychiatric assessment. Regarding the implementation of procedures for psychiatric assessment, diagnosis, and case formulation, as described in Appendix B, the self-assessment did not result in a rating of substantial compliance, although the items that were deemed by the monitoring team as vital in the determination for this section were reviewed and met substantial compliance:

- The number of evaluations that were completed out of the total number of individuals who required the evaluation; the percentage of evaluations completed with only 5% of the remaining assessments scheduled for completion.

The facility inappropriately listed J7 as failing to meet compliance. The details of how the monitoring team clearly established a substantial compliance for this provision item was summarized in the report and the monitoring team's assessment.

The self-assessment for J13 provided detailed information that only 59.5% of the 20 records had the necessary components specified in this section and therefore received a rating of noncompliance. The psychiatric assistants maintained a database of clinical contacts, but the facility did not utilize the calculated data in the self-assessment to report the number and percentage of individuals, who actually received timely psychiatric consultation for this section. For example, during the review, the facility

	informed the monitoring team that 92% of the QPMRs were done within 90 days. Treatment plans should be reflected in both the CPAs and the QPMRs, therefore, data about the components of the QPMRs and comprehensive assessments are relevant in J13. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the psychiatric assistants, lead psychiatrist, nurse compliance monitor, medical director, and other members of the psychiatric team in gathering pertinent information and data for the clinicians to review and assign a precise self-rating. To take this process forward, the monitoring team recommends the psychiatry department 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, nurse compliance monitor for Section J, and the medical director 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 but 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 consistently address the recommendations of the monitoring team. The psychiatry staff used this document to present Provision J to the monitoring team but it would be more informative to utilize the outcome of the self-assessment for the presentation next review.
	Summary of Monitor's Assessment: MSSLC met substantial compliance for five sections of provision J (J1, J2, J5, J6, J7) of the Settlement Agreement. This was a vast improvement because MSSLC did not fulfill the necessary requirements for any of the 15 provision items last review. The department had a full time lead psychiatrist and three other full time equivalent board certified psychiatrists. The facility also acquired consultation from a child and adolescent psychiatrist in the community for youth at MSSLC. This review period, psychiatric services were provided only by persons who were qualified professionals, therefore, the facility met substantial compliance in J1. The prior visit there was no child psychiatrist that provided consultative services to the facility that served minors with complex psychiatric conditions, substance use problems, in addition to forensic issues. In discussions with the lead psychiatrist, medical director, director of psychology, and the facility psychiatrists, there was improved integration. Psychology and psychiatry conducted a routine meeting together inclusive of the director of psychology, lead psychiatrist, medical director, and other staff from

	both departments. Most provision items in this section rely on collaboration with other disciplines. One of the issues discussed involved the cohesive case formulation that remained unsatisfactory. The completion of psychiatric assessments, both quarterly and Appendix B comprehensive evaluations, had progressed. The facility provided information that 95% of the evaluations, as described in Appendix B, had been completed. Psychiatry had begun incorporating the review of the behavioral support planning for individuals assigned to their own caseload at the third QPMR with the IDT present. Previously, psychiatry was not reliably 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 always provided appropriate data in order to make decisions regarding pharmacology efficacy, and per a review of records, made medication additions or adjustments in the absence of data regarding specific clinical indicators. During the onsite observation of the psychiatric clinics, the monitoring team observed the psychiatrist's attempts to conduct the psychiatric clinic, interview the individual, and review the record, while also typing the content of what was being discussed during the clinic. The psychiatric staff assigned to the clinic should discuss options of assisting the psychiatrists during the clinics as outlined in this report. 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. The practice at MSSLC illustrated individuals who were prescribed numerous medications continued to receive most of their 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 polypharmacy medications, the team did not routinely attempt to slowly decrease one of the medications and then collect further relevant information. The IDT did not resort to the utilization of non-pharmacological interventions in these scenarios and requested continued medication by the psychiatrist. In regards to pretreatment sedation, the facility needs to be cognizant of all the offsite pretreatment sedation procedures, details, and the potential effects of the medication administered to the individual, even if received at another facility. There was noted integration via the development of a desensitization committee attended by numerous staff from various disciplines, including but not limited to dental, psychology, and psychiatry. There was minimal pretreatment medications administered at MSSLC, with the majority being given at another location. This did not clear the facility of its responsibility to log, cite, and monitor individuals who have received pretreatment sedation elsewhere and then returned to MSSLC. The information reviewed in committees, such as the MRC meeting about an individual who was scheduled for pretreatment sedation, must be reviewed by the IDT and included in the individual's ISP as instructed in J4, whether received offsite or at the facility (e.g., 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 facility administered a Reiss screen for 100% of the new admissions to the facility and to everyone else at MSSLC. There was a second Reiss screen being obtained for an individual at the time of the visit because

	of a change in their status. A comprehensive psychiatric assessment and diagnosis (if warranted) was 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 who 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 IDT resisted elimination of medications that were not clinically justified. A database was used 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. The manner in which the data were presented made it difficult to follow the completion of the instruments over the course of time because data were not sequential. Therefore, it was not organized to compare scores over time. The psychiatry department must utilize this information and work together with nursing to make this process clinically applicable. There were onsite neuropsychiatric clinics that took place at MSSLC since last review. The medical director informed the monitoring team that the neurologist was now aware of the Settlement Agreement (J15) that required the facility to ensure that the neurologist and psychiatrist coordinated care, through the IDT process, when medications were prescribed to treat both seizures and a mental health disorder. The neurologist had recently begun working through the IDT process to identify 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 psychiatrists at the facility were board certified in psychiatry by the American Board of Psychiatry and Neurology. Furthermore, the lead psychiatrist, Kendall P. Brown, M.D. was board certified in geriatric psychiatry. Prakash Shet, M.D., M.B.A, was also certified in addiction medicine by the American Society of Addiction Medicine and had a Master of Business Administration in Health Care Management. Since the last review, consultation via a board certified child and adolescent psychiatrist was requested by MSSLC for a second opinion regarding diagnosis and treatment. The evaluation was obtained from Scott and White on 4/15/13 for Individual #331. The child psychiatrist noted that Individual #331 could receive follow-up at Scott and White as needed in the future. This was an important accomplishment that led to the monitoring team's designation of substantial compliance for this provision item. The facility indicated they continued to admit minors. This provision required the facility to provide psychiatric services only by persons who are qualified professionals, so the availability of a child psychiatrist must be cited in the self-assessment (J1).	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The previous medical director and the lead psychiatrist acknowledged last visit that this section previously failed to preserve substantial compliance because it did not retain access to a child psychiatrist. The monitoring team noted that it would be necessary for the child psychiatrist to 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 face to face, onsite or in the community setting, and/or via telemedicine consultation as opposed to all consultation being performed by phone. <u>Experience</u> The lead psychiatrist, Kendall P. Brown, M.D., was designated the lead psychiatrist at MSSLC 2/3/12. Dr. Brown learned about treating those with developmental disability during both his general and geriatric psychiatry training. Dr. Juanita Kirby had numerous years of experience in the field of psychiatry and worked at MSSLC since 2/6/12. 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. 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. She treated children and adolescents for numerous years and had experience of providing care for individuals with developmental disabilities. She worked at MSSLC beginning in 2011. Prakash Shet, M.D., M.B.A., started his assignment at MSSLC June 2012 and had provided psychiatric evaluations and medication management for individuals with intellectual disability and mental illness. <u>Monitoring Team's Compliance Rating</u> J1 met substantial compliance due to psychiatric services being provided only by persons who are qualified professionals. Since the last review, the facility utilized consultation with a child psychiatrist to facilitate care for youth. In order to maintain substantial compliance for this provision item, due to the facility being responsible for the care of minors, this practice must be sustained. 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.	<u>Number of Individuals Evaluated</u> At MSSLC, 241 of the 334 individuals received psychopharmacologic intervention at the time of the onsite review. The percentage of individuals receiving psychotropic medication was consistent with the previous review. <u>Evaluation and Diagnosis Procedures</u> The monitoring team observed five psychiatry clinics during the monitoring review. It was apparent that the team members attending the clinic were well meaning and interested in the treatment of the individual. The quarterly psychiatric evaluations were well organized and there was good discussion and documentation of the individual's history and presenting symptoms. 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 psychiatry department now had two psychiatric assistants and a nurse compliance monitor for section J. The medical director and lead psychiatrist should review how staff could be more involved with this process in order to better assist the psychiatrists. • 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 and/or IDT member entered some of the information. • Of course, there would be some prep time ahead of the clinic that would be necessary to accomplish this task. <u>Clinical Justification</u> The facility reported that 92% of the QPMRs were done within 90 days since the last visit and that 95% of the Appendix B evaluations had been completed. These were the two avenues to ensure that no individual received psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist. The facility provided a self-rating of substantial compliance for this provision item and the monitoring team agreed. The psychiatry staff performed a suitable job of evaluating individuals in a clinically justifiable manner, but there was a need to further differentiate psychiatric target symptoms from other maladaptive behaviors, such as self-injurious behaviors and/or aggression that were not necessarily associated with the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		assigned DSM diagnosis (reviewed further in J11). The monitoring team discussed the importance of integrating care between neurology and psychiatry via the IDT process for those individuals with a seizure disorder prescribed anti-epileptic medication and who also received psychotropic medication (J15). <u>Tracking Diagnoses and Updates</u> The facility maintained a spreadsheet that indicated changes in the Axis I diagnoses. It listed the old diagnosis, the new diagnosis, and reason for change in diagnosis. Given this information, and the review of 20 records, it was evident that the psychiatric physicians were making effort to provide clinically justifiable evaluations. The example for Individual #393 illustrated that the Quarterly Psychiatric Medication Review (QPMR) completed by the psychiatrist outlined an interim history, results of the neuroimaging study that was appropriate for this individual undergoing a dementia work-up, listing of previous diagnostics with explanation of the designated current diagnostics, case formulation, and the psychotropic treatment plan inclusive of nonpharmacologic intervention. This example highlighted the process used at MSSLC for evaluation, diagnosis, treatment recommendations, and the adequate justification for psychotropic medications. <u>Monitoring Team's Compliance Rating</u> The facility made significant progress with this provision item. The monitoring team agreed with the facility and assigned a substantial compliance rating for this provision item. Individuals prescribed psychotropic medication were evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	<u>Treatment Program/Psychiatric Diagnosis</u> Per this provision item, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medications in lieu of a treatment plan or in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis. For the majority of individuals prescribed medication, there was a diagnosis cited in the record. The monitoring team encouraged the facility to identify the diagnosis in the Doctor's Orders instead of only listing maladaptive behaviors (i.e., aggression) as the reason for the chronic use of a medication, unless it was classified as a chemical restraint upon each administration. The consent for the medication did not always list the current diagnosis for which the medication was prescribed. If the diagnosis changed, for example from Bipolar with Psychotic Features to another condition (i.e., Psychotic Disorder, NOS), the indication listed on the consent for the medication (i.e., Zyprexa for Bipolar Disorder) must be updated upon change of diagnosis.	Noncompliance

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The risk benefit analysis for the selection of the medication for the specific illness should be captured in the consent and medical documentation. Additionally, there were other occurrences where the diagnosis provided by psychiatry differed from diagnosis assigned by other disciplines. The monitoring team discovered these variances during review of records (i.e., PBSP, annual medical summary, psychological evaluation, etc.). On an encouraging note, the consent for newly prescribed psychotropic medication was converted to the responsibility of the prescribing physician (J14).

In the sample of 20 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 lack of clinical indicators identified for psychotropic medications. It was important for collaboration to occur between psychology and psychiatry to formulate cohesive differential diagnoses, case formulations, and to jointly determine clinical indicators. In this process, the IDT should discuss strategies to reduce the use of psychopharmacologic medications. It was essential that this information be documented in the individual's record in a timely manner.

<u>Emergency use of psychotropic medications</u>:
The monitoring team was provided information during the onsite visit that there were nine chemical restraints from October, 2012-March 2013. Conversely, the self-assessment summarized that the facility reviewed "14 of 14 of the total instances of chemical restraints" to determine if documentation supported that medications were not used as a punishment or for the convenience of staff. The facility noted in the results of the self-assessment that in 100% of the cases the chemical restraints were only used after a "graduated range of restricted measures" and none were used as punishment. The monitoring team outlined a sample of individuals who received chemical restraints since last visit.

<table>
<tr><th>Individual #</th><th>Date of Chemical Restraint</th><th>Medication Administered and Route</th></tr>
<tr><td>Individual #492</td><td>3/15/13</td><td>Haldol 10 mg and Benadryl 50mg IM</td></tr>
<tr><td>Individual #848</td><td>2/25/13</td><td>Ativan 2mg po and Buspar 10mg po</td></tr>
<tr><td>Individual #715</td><td>2/21/13

(Total of five chemical restraints: 2/21/13, 4/12/13, 4/17/13, 4/30/13, 5/1/13).</td><td>Thorazine 100 mg po and Ativan 1mg IM
Note: Individual received various medications for chemical restraint inclusive of Haldol 10mg IM and Diphenhydramine 50mg IM; or Lorazepam 2mg</td></tr>
<tr><td>Individual #779</td><td>1/23/13</td><td>Haldol 5 mg and Benadryl 25 mg IM</td></tr>
<tr><td>Individual #508</td><td>10/20/12</td><td>Haldol 5 mg and Benadryl 25 mg IM</td></tr>
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		Beginning in March 2013 the facility reported that chemical restraints were reviewed by the IDT, 100% within 24 hours, of the individual being given the medication. Prior data revealed there were five incidents of chemical restraints administered from 5/12/12 to 8/4/12; current data reviewed were for October 2012 to March 2013. A review of the record of Individual #779 revealed the following: • Individual #779 received a Crisis Intervention Face-to-Face Assessment and completion of the Debriefing Form within 24 hours of the incident. The outline summarized that Individual #779 had a second prior restraint for aggression towards staff (e.g., tried to cut self and staff with a sharp object). Reference was made to confirm that the correct implementation of the PBSP occurred. The individual was placed on suicide precautions earlier for threatening to "cut himself." • The psychiatrist's review within 24 hours of the incident noted Benadryl was for the prevention of an acute dystonic reaction, however, this individual already received Cogentin, an agent for the prevention of EPS. The medication was given to target extreme aggression whereby Individual #779 "had a weapon" and tried to attack staff/harm self. • The nursing staff monitored Individual #779, but noted on 1/24/13 that he did not have any adverse reactions from the medications, and listed vital signs were within stable range. Conversely, the psychiatrist documented 1/24/13 that the individual had complaints of leg restlessness, that may be a side effect of Thorazine or Trazodone and needed to be monitored, but did not specifically include the recent injection of Haldol as a potential contributant. The form filled out by the psychiatrist did not provide the score or date of the MOSES/ DISCUS, but noted possible akathisia. • The ISPA dated 1/24/13, same date of the psychiatrist's assessment, did not list the name or signature of the psychiatrist. The facility should incorporate the participation by the psychiatrist into the ISPA in order to reflect integration of care with the IDT for individuals receiving chemical restraint. • The absence of the psychiatrist's recommendations in the ISP meetings resulted in a missed opportunity to foster strategies (i.e., amendment to the interdisciplinary treatment plan) with goal of continued minimal use of emergency medication. <u>Monitoring Team's Compliance Rating</u> The facility provided a self-rating of noncompliance and the monitoring team agreed with this rating due to inconsistent integration between psychiatry and the IDT regarding treatment planning, nonpharmacological interventions, and behavioral support planning. The facility had done a nice job with regard to the minimal utilization of chemical restraints.	

#	Provision	Assessment of Status	Compliance
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 facility's documents indicated there were three administrations of pretreatment sedation at MSSLC for the past six months. The document outlined information for medical procedures 11/8/12 regarding Individual #525 and also for Individual #372 on 3/6/13 and 3/20/13. Individual #372 was enrolled in psychiatric clinic and received medical pretreatment sedation (e.g., Ativan and Benadryl). The IDT determined a desensitization program was not necessary for either of these individuals. 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 dental director informed the monitoring team that individuals expressed their desire to go on an outing in the community for their dental procedures, therefore, this was one of the reasons dental procedures did not take place at the facility. Upon further inquiry, updated data were provided to the monitoring team during the onsite review, with the aid of the pharmacy director, nurse compliance monitor for section J, and the psychiatry assistants. It was discovered there were 49 pretreatment sedations with 92% of these administered at an offsite location. These data did not specify the components of medical versus dental pretreatment sedation. The monitoring team requested 10 examples of documentation of psychiatry consultation regarding pretreatment sedation for dental or medical clinic. The monitoring team was provided none. The last review there were no case illustrations because there was no pretreatment sedation given at the facility since 3/1/12. Interdisciplinary Coordination The facility needs to be cognizant of all the offsite pretreatment sedation procedures, details, and the potential effects of the medication administered to the individual, even if received at another facility. Even though there were minimal pretreatment medications administered at MSSLC, this did not clear the facility of its responsibility to log, cite, and monitor individuals who received pretreatment sedation and then returned to MSSLC. There was useful material discussed in an interdisciplinary fashion in both the MRC and desensitization committee. The pretreatment sedation protocol effective 2/1/12 indicated that all non-emergent cases of pretreatment sedation were submitted to MRC for approval where the primary care physician, pharmacist, nursing representative, and psychiatrist were present. The psychologist assigned to the individual's treatment provided alternatives to the pretreatment sedation. The information reviewed in the MRC meeting about an individual receiving pretreatment sedation not only should be reviewed by the IDT, but also included in the individual's ISP as	Noncompliance

#	Provision	Assessment of Status	Compliance
		instructed in J4, whether received offsite or at the facility (e.g., 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 monitoring team was informed that there were no new policies for section J since the last review. The facility should be aware of and present any new and updated policies and procedures to the monitoring team that are relevant to the 15 provision items. The facility misunderstood the purpose of this provision, that is, staff should not resort to never providing 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 returned to the facility the same day and received the same routine medication regimen inclusive of possible psychotropic medication, polypharmacy, and multiple medications to target a neuropsychiatric condition unless further advised by the medical staff. The goal of this provision item was 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 were not necessary for all individuals (though certainly necessary for some individuals). <u>Monitoring After Pretreatment Sedation</u> There were only three case examples provided for this section and they revealed appropriate monitoring. 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 and/or drug-drug interactions (between these agents and the routine medications prescribed). A sample of these examples should be provided for the next review to illustrate the facility's practice pattern of monitoring after pretreatment sedation. The facility needed to be aware about the details of offsite pretreatment sedation and the potential effects of the medication administered to the individual (e.g., harmful effects of the pretreatment sedation, such as side effects and risk benefit analysis pertinent	

#	Provision	Assessment of Status	Compliance
		to the individual's medical status for each of the medications administered). Desensitization Protocols and Other Strategies 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 implemented on 7/30/12, but discontinued at the BTC 4/8/13. Similarly, Individual #196 had a dental desensitization plan implemented 3/26/12, but discontinued 4/30/13. Additionally since last visit, there was the development of dental desensitization plans for Individual #500 (implemented 2/11/13), Individual #492 (implemented 3/14/13), Individual #49 (implemented 11/19/12), and Individual #1 (implemented 2/11/13). The IDTs were beginning to address whether or not the individual required a desensitization plan in the ISP Addendum. The ongoing development of the plans, if applicable, must be individualized according to the need and skill acquisition level of the individual, along with specific personalized reinforcers that would be desirable for the individual. Monitoring Team's Compliance Rating Calculation of pretreatment sedation that was given for dental or medical purposes at any offsite facilities must be incorporated into the MSSLC data set. The facility must also track the implementation of monitoring after pretreatment sedation upon the individual's return to MSSLC. The facility provided a rating of noncompliance and the monitoring agreed that this item remained in noncompliance.	
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.	Psychiatry Staffing Approximately 72% of the census received psychopharmacological intervention requiring psychiatric services at MSSLC as of 6/3/13 (a total of 241 individuals). Of these, 65 individuals were age 18 or younger. There were a total of four FTE psychiatrists at MSSLC. The lead psychiatrist, appointed 2/3/12, was an employee of the facility and had the responsibility of managing 38% of the clinical caseload in addition to addressing the provision items in provision J. The other three full-time equivalent psychiatrists had less individuals assigned to them (e.g., 16%, 19%, and 27% of individuals who required psychiatric services). The facility self-assessment inaccurately cited "the current caseload has been constant and continues to average 60-70 per psychiatrist." The psychiatric clinic schedule listed each psychiatrist as working 40 hours each week. The psychiatric staff rotated on call a week at a time. The facility reported that each psychiatrist attended ISPs, ISPAs, CLDPs, Polypharmacy Meetings, MRC, Pharmacy and Therapeutics, and other various meetings. The lead psychiatrist also attended the PET and the QAQI meetings.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility previously calculated that four FTE psychiatrists would be required to address the following duties: • provide care for an average of 60-70 individuals assigned to their caseload; • completion of Appendix B comprehensive assessments; • 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. There was a newly appointed nurse compliance monitor for section J, Ms. Angela Johnson, R.N. She would track and trend psychiatric assessments completed for timeliness and quality, collect and organize data, and assist in document preparation (i.e., self-assessment, action plans, etc.). <u>Determination of Required FTEs</u> 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, ISP/ISPA emergency attendance, discussions with nursing staff, call responsibility, and participation in polypharmacy meetings). <u>Monitoring Team's Compliance Rating</u> The facility provided a self-rating of substantial compliance in the self-assessment for this item because of the adequate number of psychiatrists. There were four FTE equivalent psychiatrists at MSSLC at the time of the visit. MSSLC demonstrated the ability to employ or contract with a sufficient number of psychiatrists to provide the services required, therefore, this provision was assigned a rating of substantial compliance.	

#	Provision	Assessment of Status	Compliance
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	<u>Appendix B Evaluations Completed</u> MSSLC provided data that 95% of the individuals receiving psychiatric services had an Appendix B evaluation completed. There were 13 individuals in the process of being scheduled to receive their evaluation. Given the number of completed comprehensive psychiatric assessments, this provision met substantial compliance. Appendix B style evaluations were reviewed for the following 10 individuals: Individual #905, Individual #884, Individual #779, Individual #761, Individual #406, Individual #462, Individual #347, Individual #476, Individual #139, and Individual #888. All Appendix B evaluations included case conceptualizations and history that reviewed 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. Treatment recommendations inclusive of non-pharmacological interventions were included in the documentation. The assessments followed the Appendix B outline and reflected adequate documentation. Below are comments from the monitoring team. • The monitoring team encouraged documentation of orthostatic blood pressure and pulse (i.e., lying/standing BP and lying/standing pulse) for individuals who received 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 were 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. • Treatment recommendations to include indication of each medication and to review potential drug-drug interactions and risk benefit analysis of each medication. • Neuropsychiatric consultation to be requested if applicable for individuals with a seizure disorder receiving AED medication, inclusive of benzodiazepines, in order to address clinical care as outlined in J15. • The psychiatrist must guide the IDT in a detailed fashion about what psychiatric target symptoms to monitor in order to determine medication efficacy.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Monitoring Team's Compliance Rating The facility self-rated noncompliance, however, the monitoring team ascribed substantial compliance for this provision item. The monitoring team encouraged the facility to use this report to emulate and report similar findings.	
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.	Reiss Screen Upon Admission 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 52 new admissions since last visit. The director of the psychology informed the monitoring team that 100% of individuals admitted to MSSLC received a Reiss Screen within 30 days of their admission date. All new admissions received or were scheduled to receive a comprehensive psychiatric evaluation (if pertinent), so there were no separate referrals for psychiatric evaluation following the Reiss screen. Reiss Screen for Change in Status Individual #549 recently had a change in status and was in the process of receiving a Reiss screen that was reported to the monitoring team by the psychology director. This was good to see. Reasonable timelines (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) should be considered and tracked by the facility. Reiss Screen for Each Individual (excluding those with current psychiatric assessment) Per interview with the psychology director, these individuals received a Reiss Screen. The psychology and psychiatry department reviewed the data of J7 together in order to have the same information and to determine whether or not an individual had a need for psychiatric services. MSSLC provided a spreadsheet of all individuals who had a Reiss screen 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, if applicable. This section required that all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication received 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. Monitoring Team's Compliance Rating The self-assessment did not reflect compliance, but upon the review by the monitoring team, J7 was in substantial compliance. Given the successful completion of the components outlined in this provision item, inclusive of individuals with a psychiatric diagnosis or prescribed psychotropic medication receiving a comprehensive psychiatric assessment and	Substantial Compliance

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		diagnosis (if a psychiatric diagnosis was warranted) in a clinically justifiable manner, this provision met substantial compliance. The monitoring team encouraged the facility to use this outline to guide its activities for future reports.	
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.	Policy and Procedure The SSLC statewide policy and procedure for psychiatric services was updated 5/1/13 and should be fully implemented by each state center on or before 7/1/13, therefore, for the purposes of this review, the SSLC statewide policy and procedure for psychiatric services dated 8/30/11 will be referenced. The policy included 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." The facility informed the monitoring team that the facility specific policy regarding psychiatric services implemented 12/1/11, "Medical #17," was revised and the psychiatry department was awaiting final approval. Interdisciplinary Collaboration Efforts In order to address this provision item, the facility held a psychiatry/psychology integration forum 20 times from 10/1/12 to 3/31/13. The monitoring team attended the psychiatry/psychology integration meeting on 6/6/13. There were multiple positive outcomes from these interactions. The staff from both departments discussed ways of addressing combined assessment and case formulation. Psychiatry informed psychology that the case formulations were now available in some of the QPMRs. One of the goals in development of a system at MSSLC was for all of the QPMRs to contain a case formulation. This process would facilitate staff awareness about updated diagnostics in the record for review by the multidisciplinary team. All four of the facility psychiatrists participated in the psychiatry/psychology meeting in addition to the psychology director, medical director, and other multidisciplinary team members. One of the issues discussed reflected the psychiatrists' concern about receiving lack of "useful information." Psychiatry staff indicated that it was not helpful to only learn about "tracking behaviors." Psychiatry requested psychology to provide data in reference to the psychiatric target symptoms relevant to the assigned diagnosis. Psychiatry staff expressed interest in receiving more objective data (e.g., BPRS), and other information about the individual to facilitate determination of medication efficacy in an updated manner. 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 review of information provided during the time of the clinic. The psychiatrist met with the individual and his or	Noncompliance

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		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. Integration of treatment efforts between psychology and psychiatry 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 target symptoms that were deemed necessary for monitoring of the current psychiatric diagnosis. One of the contributing factors was the result of the psychiatrist not being consistently focused on the reason the medication was prescribed. Instead, the IDT inquired predominantly about behavioral presentation, such as aggression and SIB. Collaboration should be evident in psychiatry clinic, the psychiatric treatment plan, psychiatric assessment, nursing assessment, Active Problem List, the ISP process, the PBSP process, and, hopefully, with other 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 because effective treatment relies upon cohesive diagnostics. For example, Individual #466's diagnoses were found to be inconsistent across documents. 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). The monitoring team discovered that the facility had not developed an adequate system to ensure the integration of pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	

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A detailed summary of these discrepancies is outlined for Individual #466 below:

Document	Axis I Diagnoses
Psychological Evaluation (2/21/13)	*Undifferentiated Somatoform Disorder*; Schizoaffective Disorder, Bipolar Type; IED; *Cluster B Traits*
Comprehensive Nursing Assessment (3/22/13 implementation date)	Schizoaffective Disorder; IED
Transfer Note: Psychiatrist (5/22/13)	Schizoaffective Disorder; IED; *History of Seizure Disorder*; Traumatic Brain Injury
Active Problem List (5/30/13)	Somatoform Disorder; *History of Pica with recurrent Foreign Body Ingestion*; Schizoaffective Disorder, Bipolar Type; IED; Borderline Personality Disorder; Seizure Disorder
Drug Regimen Review Profile (6/3/13)	Guanfacine was added 4/24/13 for indication IED for this individual who received Metoprolol for Hypertension; Divalproex ER was also prescribed for IED, not listed for seizures on the drug profile; Clonazepam 5mg/day initiated 4/29/13 on a continuing basis for "*severe agitation;*" Quetiapine 800mg/day for Schizoaffective Disorder; Lithium CR for mood stabilization

Combined Assessment and Case Formulation

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., as outlined per Appendix B including biological, psychological, social, and spiritual), creation of clinically based expectations 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. For example upon the record review for #466, the QPMR dated 5/6/13 noted that Depakote was "initially for seizure disorder and we are hoping that it is helping his mood," but the Drug Regimen Review Profile dated 6/3/13 indicated that Divalproex ER 200 mg/day was for Intermittent Explosive Disorder. The clinical indicators/target behaviors for Depakote only listed seizures. Some of the interdisciplinary documents did not cite Seizure Disorder as a concern. The IDT needed to match the indication for Depakote throughout the entire record for this individual who had an identified neuropsychiatric history of prior traumatic brain injury and seizure disorder. Furthermore, in any case example, if agents, such as AED medications were prescribed for the initial purpose of seizures, and then the team

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		determined the indication was also intended for mood stabilization or IED, appropriate consent with a new risk benefit analysis must be obtained. The AED must be included in the psychotropic count in such instances. The topic of neuropsychiatric integration will be further discussed in J15. This practice pattern posed problems 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> The team had not consistently 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 psychiatric target symptoms to determined medication efficacy pertinent to the established diagnosis. There were, however, the beginnings of integration between psychiatry and psychology, specifically opportunities for interaction during psychiatry clinic with the psychologist and other disciplines. More than one psychiatrist was responsible for the psychiatric care of some individuals and as a result, diagnostics and treatment regimens changed. When this occurred without the integration and support of the IDT, and without a history of combined case formulation, psychiatry and psychology will not be (and were not) aligned. 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> The monitoring team agreed with the facility's rating of noncompliance for this provision item. The monitoring team's decision was based on the issues cited in the report, such as paucity of cohesive combined assessment and case formulation across disciplines.	
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	<u>Psychiatry Participation in PBSP</u> During prior reviews, 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. The facility had now incorporated a review of the PBSP during the third QPMR conducted with members of the IDT present. Additionally, a list of all meetings and rounds attended by the psychiatrist was provided to the monitoring team. These meetings included ISPs, ISPAs,	Noncompliance

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	the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	Psychiatry/Psychology interactions, physicians' meetings, medical review committee, psychoactive medication polypharmacy review committee meetings, psychiatry scan calls with other SSLCs, neurology scan calls with Scott and White, QAQI council, and PET II. The psychiatrists elected to no longer attend the BTC process because this type of information was now being reviewed in the third QPMR. This forum was deemed to be the appropriate place to determine the least intrusive and most positive interventions for the individuals' care. In order to meet the requirements of this provision item, there needs to be evidence that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item, and that the required elements are included in the document. <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. The monitoring team attended the BTC and noted that the behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports, were not necessarily chosen due to the identified psychiatric diagnosis. The monitoring team was encouraged when psychology staff updated diagnostics that were not consistent with the current psychiatric diagnosis during the BTC. The monitoring team recommended for the psychiatrist to meet with the IDT before a proposed PBSP for individuals receiving psychiatric care was implemented. <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> During the psychiatric clinics observed, the IDT predominantly requested the psychiatrist's continued prescription for the psychotropic medication regimen. There was minimal 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 support and record the participation of the psychiatrists in the various meetings. • The psychiatric database of a numbered spreadsheet of individuals prescribed psychotropic medication had 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. • The monitoring team received a document dated October 2012 "ISP Attendance Tracking" that summarized overall ISP attendance tracking of team members (i.e., OT, PT, Individual, LAR, Psychiatrist, Nutrition). o This document highlighted that psychiatrists only attended a total of 3 out of 31 meetings in October 2012. Similar findings were illustrated	

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		regarding the absence of psychiatrists in the ISP meetings in November 2012 (6% attendance). o The facility should make these data more relevant for the actual calculation of mandated psychiatric participation in the ISP meetings. If there were 30 ISP meetings in a particular month, but only 15 of these meetings required the attendance by the treating psychiatrist, then this calculation should be available for review. o Similar to the ISP attendance tracking of team members, MSSLC should collect data about which specific IDT meetings psychiatric staff attended, preferably within the numbered spreadsheet of individuals prescribed psychotropic/psychiatric medication for each individual. <u>Monitoring Team's Compliance Rating</u> The monitoring team agreed with the facility's self-rating of noncompliance. This rating was given due to the psychiatrists' lack of involvement in the development of the PBSPs and their inadequate level of involvement in the ISP process to determine interventions through the IDT, both pharmacological and nonpharmacological. It would be helpful in future monitoring reviews for the psychiatry department to indicate <u>where</u> this review was documented in the record and to provide the <u>names</u> of those individuals who were reviewed, so that a sample of these records can be requested.	
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> The SSLC statewide policy and procedure for psychiatric services was updated 5/1/13 and should be fully implemented by each state center on or before 7/1/13, therefore, for the purposes of this review the SSLC statewide policy and procedure for psychiatric services dated 8/30/11 will be referenced. A review of DADS policy and procedure entitled "Psychiatry Services," dated 8/30/11, noted that state centers "must ensure that individuals are evaluated and diagnosed by a psychiatrist prior to administration of psychotropic medications…The psychiatrist, in conjunction with the PST and pharmacist, must conduct quarterly reviews of the assessment of the risk versus benefit of continued psychotropic medication therapy as well as the appropriateness of drug selection, effectiveness, dosage, and presence or absence of side effects." The facility informed the monitoring team that the facility specific policy regarding psychiatric services implemented 12/1/11, "Medical #17," was revised and the psychiatry department was awaiting final approval. <u>Quality of Risk-Benefit Analysis</u> The electronic QPMR form provided a section for the psychiatrist to list risks, benefits, potential side effects of a medication regimen, and alternative treatments. This provision item required the IDT, including the psychiatrist, PCP, and nurse, to determine whether the	Noncompliance

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		harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication. The IDT continued to struggle with an integrated determination of the actual psychiatric diagnosis even regarding the new admissions to the facility. The facility must have a designated active problem list that should match all of the disciplines' diagnostics. There was a pervasive pattern at MSSLC that impacted several provision items in section J due to lack of cohesive case formulation and thus incongruent diagnostics. The risk benefit analysis was skewed because different disciplines cited different reasons for the utilization of the psychotropic medications. For example, the PBSP for Individual #851 dated 2/20/13, not signed by a psychiatrist, and without a designated signature line for the psychiatrist, outlined that this individual had Posttraumatic Stress Disorder (by history), Bipolar Disorder NOS (by history), Mood Disorder (by history), ADHD NOS (by history), Oppositional Defiant Disorder (by history), and Moderate Mental Retardation (by history). The psychotropic medications listed in the PBSP were "Zyprexa, Clonidine, Wellbutrin, and Concerta for Bipolar Disorder (by history)." • Conversely, the Comprehensive Nursing Assessment completed 2/20/13-3/18/13 listed the current diagnoses as Pervasive Developmental Disorder, Attention Deficit Hyperactivity Disorder, Bipolar Disorder, and Oppositional Disorder. • The Physician's New Admission Medical Review (Assessment) 2/22/13 listed Pervasive Developmental Disorder, ADHD predominantly hyperactive impulsive type, Bipolar Disorder, Oppositional Defiant Disorder, but did not list a diagnosis of intellectual disability (mild or moderate mental retardation). • Documentation for Individual #851 provided to the monitoring team regarding the initial psychiatric visit completed by the psychiatrist dated 2/28/13 did not list any of the team members' signatures, not even the psychiatrist's signature. The diagnoses given by the psychiatrist were Bipolar Disorder, Not Otherwise Specified, ADHD, and Mild Intellectual Deficit. • The diagnostics listed in the ISP dated 3/18/13 were consistent with the nursing assessment. The psychiatrist was deemed not present in the ISP due to absence of signature. The ISP noted that the Bupropion (Wellbutrin) was discontinued. This provision item required the IDT's integration of care involving least restrictive treatment. Unfortunately, it was apparent due to the record reviews by the monitoring team of 20 individuals who were prescribed various psychotropic medications, that psychiatric diagnostics varied amongst the disciplines. The treatment plan and risk benefit analysis must have a specific unified diagnosis upon which the IDT based the intervention. The plan developed for an individual with Pervasive Developmental Disorder would be distinctly different from someone with Post Traumatic Stress Disorder or Bipolar Disorder.	

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		The psychiatric physicians had begun to initiate a risk benefit analysis with regard to treatment with medication in the QPMRs, however, did not always include a separate risk benefit analysis for each medication prescribed. Individual #851 was prescribed Zyprexa and Bupropion at the time of the initial psychiatric evaluation dated 2/28/13. The psychiatrist combined both of these medications in one risk benefit analysis and it was difficult to read and understand the content written in this manner. The risk benefit assessment section again summarized "behavior problems, challenging behaviors that have put him and others at risk, and the benefit of the medication far outweighs the risk of the side effects." This type of generalized statement was not an adequate risk benefit summary. The psychiatrists obtained consent for psychotropic medications instead of the psychology department. This was a large undertaking and will take time to generate an adequate risk benefits analysis for those individuals prescribed psychotropic medication. There was similar language used for the medication plan no matter what class of medication was prescribed, therefore, the plans were not individualized. Potential side effects outlined were not sufficient for each medication utilized. Alternatives listed for Individual #851 noted "BSP and therapy alone," however, this individual was diagnosed by the psychiatrist with "bipolar mood disorder," therefore, this did not seem like an appropriate evidence-based alternative treatment. The exercise of thinking through the risk benefit of each medication for the established diagnosis should result in the decreased use of unnecessary medication. 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. The IDT must review and document relevant drug-drug interactions and review the effect the psychotropic medications on an individual's medical condition (i.e., worsening of glucose control for an individual with diabetes mellitus prescribed an agent such as Zyprexa or other atypical antipsychotics). It will also require that appropriate data regarding the individual's target symptom monitoring was provided to the physician, that these data were presented in a manner that was useful to the physician, that the physician reviews said data, and that this information was 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 considered the potential side effects of each psychotropic medication, weighed those side effects against the potential benefits, included a rationale as to why those benefits could be expected, a reasonable estimate of the probability of success, and the establishment of reasonable alternative	

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		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. It was apparent that the psychiatrist struggled with completing multiple tasks without assistance with the typing of relevant information while reviewing the record and attempting to interview the individual, all at once. 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. <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 regards to the prescribing physician being the responsible party for obtaining consent and, thus, establishing the risk benefit analysis, challenges remained as outlined in the report. Given these deficiencies, the monitoring team agreed with the facility rating of noncompliance. In summary, 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.	
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	<u>Facility-Level Review System</u> The lead psychiatrist reported that the "polypharmacy teams are now placing more emphasis on discussion of potential drug-drug interactions and ADRs, by increasing the discussion between the pharmacist, primary care physicians, and the psychiatrists at the meeting." The psychiatry department must be knowledgeable about all policies and procedures developed and revised affecting the collaboration and integration of services for the delivery of psychiatric services. For example, the psychiatry department should consider the Quarterly Drug Regimen Review policy and procedure 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.	Noncompliance

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	medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	The intention of the monthly polypharmacy committee was a facility-level review to ensure that the uses of psychotropic medications were clinically justified, and that medications that were not clinically justified were eliminated. The facility psychiatrists and IDT have not yet grasped this concept. The team members consistently defended the addition of more psychotropic medications particularly when individuals struggled with maladaptive behavior towards self and others. Medications, such as benzodiazepines, were prescribed on a continuum for aggression/agitation instead of the facility factoring in the etiology of the individuals' presentation, such as being upset due to environmental factors versus exacerbation of a psychiatric condition. 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 were 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 was receptive to feedback by the monitoring team. 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. 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. 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 present this review, as the existing facility level review process was prepared regarding the individuals' case specifics, illustrated a peer review process whereby other psychiatrists questioned the prescribing physician about the rationale for the use of medication, inquiries were posed concerning clarification of diagnostics and the indication for the AED medication. <u>Review of Polypharmacy Data</u> The results of the April 2013 data indicated the following: • There were 95 individuals prescribed polypharmacy; • There were 253 individuals prescribed psychoactive medications; • 37.5% polypharmacy cases; • Individual #715 received <u>seven</u> psychotropic medications; • Other data reflected another individual was prescribed six medications;	

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		• 10 individuals received five medications; • 27 individuals received four medications; • 59 individuals received three psychotropic medications; • 32 individuals were classified in the intraclass within polypharmacy category • Three individuals received "Pure Intraclass" of two medications The last review, the results of the August 2012 data indicated there were 103 individuals prescribed polypharmacy of the 266 receiving a psychotropic regimen. Thus, there were 39% polypharmacy cases at MSSLC. Data from the April 2013 P& T meeting noted the change in the count of polypharmacy included variables, such as discharges from MSSLC (Individual #332, Individual #491), seven individuals no longer prescribed a polypharmacy regimen, and new admissions already prescribed psychotropic polypharmacy. In summary, the facility made progress with capturing the necessary information that would drive the next step of the psychiatrist's review within an IDT format to ensure that the use of such medications was clinically justified, and that medications that were not clinically justified were 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, provided upon inquiry by the monitoring team in psychiatric clinics) highlighted IDT's efforts towards the topic of justification of the utilization of psychotropic medications, specifically polypharmacy. The monitoring team attended the polypharmacy committee during the onsite visit. A packet was available for the committee that listed the 95 individuals who received psychoactive medication polypharmacy, psychiatric diagnoses, psychoactive medications, target symptoms, and discussion category/status update. This summarized information facilitated the case presentations that were pertinent to the intention of the review. For example, the committee had a lengthy discussion due to the difference of opinions about the indication of the medication for Individual #715 who received seven psychotropic medications (discussed in J8), in addition to four chemical restraints (4/12/13, 4/17/13, 4/30/13, 5/1/13). It was imperative that the psychiatry department and the pharmacy department had 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 prescribed, nonpsychotropic and psychotropic, for each individual reviewed in order to determine the next plan of action. The pharmacy provided the Drug Regimen Review Profiles for the individuals presented in the polypharmacy committee.	

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		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, 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 findings of the QDRRs (section N) remained very important. <u>Monitoring Team's Compliance Rating</u> The pharmacy department made progress in setting up a system level of review of polypharmacy, but the psychiatrists (with the IDT) needed to focus on the justification of the prescription of the polypharmacy regimen. The outcome should then be reflected in the polypharmacy committee's summary. The monitoring team agreed with the facility self-assessment's rating of noncompliance for this provision item.	
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.	<u>Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS)</u> The facility self-assessment noted that 80% of 30 records had a MOSES and DISCUS completed consequently gave a noncompliance rating for this section. The DUE summary data outlined in section N confirmed the deficiency in the completion of the MOSES and DISCUS. The facility provided information regarding scores and dates of completion of evaluations dated October 2012 through March 2013. The data were presented for each month, including the individual's name, DISCUS score, MOSES score, and the dates of completion. The manner in which the data were presented made it difficult to follow the completion of the instruments over the course of time because data were not sequential. Therefore, it was not organized to compare scores over time. A revision in the presentation of data into a spreadsheet may assist with tracking both the completion of the instruments over time and changes in scores prompting further clinical evaluation. Review of this information revealed delay in completion of the DISCUS given that the goal was administration every three months. For example, on 10/1/12 Individual #401 had a DISCUS score of 6 but failed to have an additional DISCUS administration until 3/28/13 (score was not listed). The reason for the delay was not explained. Individual #401 was not identified by the facility as having TD. The psychiatry department must utilize this information and work together with nursing to guarantee this process was clinically applicable and requested the updated information if the individual was not administered the screens for the purpose of monitoring potential side effects of psychotropic medication.	Noncompliance

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		The facility should summarize the findings for this section, such as the total number and percentage of individuals who received the DISCUS and the MOSES in a timely fashion. It may be helpful to identify reasons for the deficiencies (i.e., individual was discharged from the facility or no longer received psychotropic medication). This type of data can aid the facility with self-assessment rating concerning the requirements of this provision item. <u>Training</u> The annual training for the MOSES and DISCUS was attended by 25 of 27 nurse case managers. There were two newly hired case managers with a projected completion date of training 7/1/13. Staff also received training regarding adverse drug reactions in sequence with the MOSES/DISCUS training as recommended by the monitoring team. This provided an opportunity to associate the monitoring/detecting via screens with reporting (i.e., ADR) and responding to the clinical presentation. <u>Results of the Side Effect Rating Scales</u> The names of 11 individuals were provided to the monitoring team that had the diagnosis of tardive dyskinesia (TD). The knowledge about the history of exposure to prescribed medications, such as neuroleptics and metoclopramide, was also necessary to assess the risk of TD. No individual was prescribed Reglan at the time of the review. Detecting, reporting, and responding to side effects of psychotropic medication, secondary to interpretation of the scales, is a complex task. For example, Individual #142 was examined by the psychiatrist in the QPMR forum 3/14/13 with notation that the DISCUS assessments were probably inaccurate and under rated (score of 3 over the past year) because Individual #142 had moderate movements of his toes, fingers, wrists, and arms. The psychiatrist discussed these findings with the nurse and the team with supportive documentation that the MOSES score of five was due to mouth movements and drooling. This was an excellent example of detecting side effects of psychotropic medication for this individual who was prescribed a psychotropic polypharmacy regimen. The psychiatrist noted Individual #142 had difficulty undergoing a decrease of medications due to worsened symptoms. • 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. • Some individuals with tardive dyskinesia may actually require a low dose of an atypical antipsychotic to suppress and/or ameliorate abnormal motor movements. If this was the chosen reason for the continuation of the agent, then appropriate consent should be obtained.	

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		The evaluator must also 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, or motoric movements caused by cerebral palsy would not warrant TD diagnosis unless otherwise indicated. Once side effects were detected, reporting was to occur and response taken based on the individual's status. Adverse Drug Reactions were reviewed in section N. For example, Individual #593 received a combination of Olanzapine and Citalopram and had tremor, shakiness, and agitation with a probable association. The recommendations listed on the ADR Report September 2012 provided by pharmacy were continued MOSES/DISCUS monitoring without any mention if either of these medications were to be considered for possible simplification. The monitoring team discussed the importance of the risk/benefit analysis and justification of continuation of medications in J10. <u>Monitoring Team's Compliance Rating</u> The facility should compose a comprehensive summary, inclusive of the total number and percentage of individuals who received the DISCUS and the MOSES in a timely fashion. The record lacked pertinent medical history about exposure to medications that potentially caused TD, therefore, did not utilize this necessary information in clinical decision-making. The monitoring team recommended the psychiatry department to work with nursing and pharmacy department to address this provision. The monitoring team agreed with the facility's rating of noncompliance for this provision item.	
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	<u>Policy and Procedure</u> The new SSLC statewide policy and procedure for psychiatric services should be fully implemented by each state center on or before 7/1/13. 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. The facility informed the monitoring team that the facility specific policy regarding psychiatric services implemented 12/1/11, "Medical #17," was revised and the psychiatry department was awaiting final approval. <u>Treatment Plan for the Psychotropic Medication</u> The self-assessment revealed 59.5% of the 20 records demonstrated the treatment plan components for psychotropic medication relevant to this provision item thus rated this provision item in noncompliance. There was implementation of an electronic QPMR for the psychiatric documentation. The new format had sections that allowed for justification for the previous diagnosis and current diagnosis, timeline for medication effects, and psychiatric symptoms monitored for efficacy.	Noncompliance

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	characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	If a psychiatrist changed a diagnosis, the IDT should be aware of the reasons for the choice of the new diagnosis over the old one, and 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. 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 satisfactorily outlined in the records. Examples of QPMRs in the new electronic format were provided to the monitoring team. Individual #997 was an example of the format implemented in psychiatric services since last visit. The documentation included a psychotropic medication treatment plan for Seroquel, with applicable indication/target symptoms listed (e.g., hallucinations, mood stabilization) for this individual with a diagnosis of bipolar disorder, depressed with psychotic features. The timeline for the medication effect summarized that Individual #997 received Seroquel for several months and was "doing fairly good with it." Ironically, Trileptal was recommended during this QPMR for the inadequate control of symptoms. These details required more attention from the IDT in order to justify the utilization of additional medication in order to avoid a pattern of polypharmacy. The timeline of medication effect for the Trileptal was deemed to be two to four weeks. The psychiatric symptoms listed to assess efficacy were sleep, appetite, mood swings, depression, mania, hallucinations, and suicidal ideations. The case formulation noted the treatment plan monitoring would be done by all disciplines involved in the treatment. The psychologist would monitor the behavior program, targeted behaviors of aggression and inappropriate sexual behaviors, as well as the psychiatric symptoms. 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 must be congruent with content of the QPMR form completed by the psychiatry department with input from the IDT. The psychiatry department must consider 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 cite a general statement in the example for Individual #997 that recommendations by the pharmacist will be "followed up." Section N provided information regarding the paucity of EKGs obtained, so the individualized plans must correct these specific findings. The QDRRs, when performed timely, were available as a tool developed for systematic review for those individuals receiving medication, such as psychotropics. The sharing of information between disciplines must be a basic, standard, accepted process, especially due to the numerous	

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		changes in clinical case assignment that occurred in the psychiatry department. <u>Psychiatry Participation in ISP Meetings</u> There was minimal psychiatry participation in the ISP process since last review (addressed in J9). The facility had a full complement of psychiatrists that allowed for their participation in the ISP/ISPA meetings. In an effort to utilize staff resources most effectively, the facility incorporated some components of the IDT meetings into the third QPMRs. 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>Frequency of Consultation with the Psychiatrist</u> The two full time psychiatric assistants who coordinated the psychiatrists' schedules and the clinic management informed the monitoring team that individuals were to be seen in clinic at a minimum of once per quarter for their quarterly medication review. Data were presented in J2 that 8% of the QPMRs failed to be completed within 90 days and 5% of the Appendix B evaluations were in the process of being finished since the last onsite review. These data should always be included the facility self-assessment. 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, no shows, scheduling conflict, illness, hospitalization, etc. 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. <u>Psychiatry Clinic</u> During the monitoring review, several psychiatry clinics were observed. The psychiatry clinics were held concurrently during the week of the onsite review. The monitoring team observed a psychiatry clinic conducted by each of the four psychiatrists. The neuropsychiatry clinic was not held during the week of the visit (discussed further in J15). Treatment team disciplines were represented during each clinical encounter that was observed. Further, the teams did not rush clinic, spending an appropriate amount of time (i.e., minimum of 30 minutes) with the individual and discussing the psychotropic treatment plan. • There was tension noted when the psychiatrist mentioned the consideration of reduced psychotropic medication during the onsite observation of psychiatry clinic for Individual #475. The psychiatrist requested information to determine whether the individual required the antidepressant medication. The individual was laughing, in a playful mood, recently moved to the S1 home that had fewer residents, and had done "very well there." The individual appeared comfortable in	

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		the interaction with the psychiatrist and the IDT. • There were no clear data presented to the psychiatrist regarding depressive symptomatology because the BSP that was reviewed in the QPMR noted target behaviors of aggression towards others, refusing to follow instructions, and unauthorized departure. • The psychology staff indicated Individual #475 was new to her caseload. Upon inquiry by the monitoring team about how the team monitored treatment efficacy (i.e., objective measures/BPRS), the psychology staff commented that a Beck Depression Scale could be administered. • The copy of the QPMR dated 6/6/13 provided to the monitoring team was not thoroughly completed and not signed by the team members in attendance. Delegation regarding the responsible party's completion of tasks in order to have a useful clinic must occur between the medical director, psychology director, and the lead psychiatrist. The adversarial discussion illustrated in the psychiatric clinic for Individual #475, in the individual's presence, fortunately resulted in a peaceful resolution because of the psychiatrist's agreement not to alter any medication due to the individual's recent move. Furthermore, the 6/6/13 QPMR summarized events such as the lack of the development of a new BSP at the time of the 3/11/13 QPMR when Individual #475 became more aggressive with Clonidine and complicated by the treating psychologist's absence (medical leave). The IDT in the psychiatric clinic must provide assistance to the psychiatrist who has many items to address such as reading the documents, discussion with staff, interview of the individual, typing of the input provided by the IDT, and in this case an arbitrator. <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 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	

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		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 with associated aggression, medications would be appropriate to target aggression towards others or self-injurious behavior until stabilization of the psychiatric symptomatology occurred. In most cases, the psychiatrist displayed competency in verbalizing the rationale for the prescription of medication, for the biological reason(s) that an individual could be experiencing difficulties, and for how a specific medication could address said difficulties. This information, however, must be spelled out in the psychiatric documentation. During the review, it was discussed with 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. Both departments were determining how they could assist each other and what information and services were necessary to obtain from the each other. <u>Monitoring Team's Compliance Rating</u> The monitoring agreed with the facility's rating of noncompliance. A review of 20 records revealed varying quality in documentation for the psychiatric reviews. The IDT must focus on the establishment of a unified clinically justifiable diagnosis, reflected in the record (e.g., psychiatric diagnosis consistent in QDRRs, physician's assessments, psychology assessments, nursing assessments, IDT assessments) and identify psychiatric target symptoms associated with the diagnosis in order to determine efficacy of the chosen treatment. These deficiencies must be remedied to ensure that the treatment plan for the medication was based on the individual's current status and/or changing needs.	
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	<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." <u>Current Practices</u> The psychiatrists were delegated the responsible party for obtaining informed consent for any new psychotropic medications instead of the psychology staff. Consent was now the duty of the medical/psychiatric department that was an achievement toward obtaining proper legal authorization prior to the administration of psychotropic medications. The	Noncompliance

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	medications or restrictive procedures and shall identify associated risks.	psychology staff had been responsible for the coordination of consent for psychotropic medication due to prior difficulty with the hiring and retention of psychiatry staff. The medical and psychology departments in addition to the monitoring team were all in agreement with this plan. The psychiatrists completed 82 informed consents with legal authorizations from 10/1/12 to 3/31/13. The facility did not provide the total number of new medications or the total number of consents that were pending completion. The consents reviewed by the facility were deemed to include the following: specific risks, expected benefits, expected timeline for therapeutic effects, alternatives to treatment, and the effects of lack of treatment. The monitoring team was provided the new template via the consent completed 3/28/13 for Individual #863. The form was appropriately named MSSLC "Consent To Treatment-Psychotropic Medication. The content of the form included the clinical diagnosis of major depression, with a behavioral-pharmacological hypothesis section that listed "to treat depressive symptoms." The medication Celexa was an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs) that was an appropriate selection for major depression. Medication side effects were summarized with reference from the Physician Desk Reference including common, serious but rare, and very serious but rare categories. The document noted that the complete list of possible side effects was not complete and if the individual noticed other effects not listed, contact the doctor or pharmacist. Other symptoms should also be relevant according to gender. The facility must remain alert about black-box warnings for all psychotropic medications such as antidepressants when prescribed for youth (Celexa, Luvox, Paxil, Prozac, Zoloft, Effexor, Remeron, Serzone, and Wellbutrin). While this was progress, it would be helpful to list further detail. • For example, Individual #863 had elevated blood pressure readings as cited by the psychiatrist. In the event that a psychotropic medication could potentially cause and/or exacerbate vital signs, and the individual actually had abnormal vital signs, then this type of data should be personalized in the individual's risk benefit analysis component of the consent process. • The PBSP with date of implementation 3/21/13 did not list major depression. The diagnoses were attention-deficit/hyperactivity disorder, combined type (by history) and conduct disorder, childhood onset (by history). This was another example of lack of cohesive diagnostics affecting identification of psychiatric target symptoms that required monitoring for medication efficacy. The expected timeline for the therapeutic effects of the medication to occur were listed, 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,	

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		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 (e.g., competent major) and confirm the legal role of others when signing consents on the individual's behalf. There were no families/LARs who refused to authorize psychiatric treatments and/or medication recommendations this review period. A consent form, once completed, was then presented to the Human Rights Committee for review before a non-emergency medication was given. To summarize, current facility practice was in development of being consistent with generally accepted professional standards of care that required the prescribing practitioner disclose to the individual (or 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 monitoring team agreed with the facility's rating of noncompliance. The psychiatry department was in the initial stage of directing the informed consent process prior to dispensing psychotropic medication.	
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. <u>Individuals with Seizure Disorder Enrolled in Psychiatry Clinic</u> The monitoring team received a numbered alphabetized list of 81 individuals participating in psychiatry clinic who had a diagnosis of a seizure disorder. Last visit, there were 53 individuals, a data difference of 28 individuals. This review period there was an improvement in the accuracy of this count for determination of individuals who required 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 similar with the pharmacy data in order to keep track of those in need of neuropsychiatric evaluation(s).	Noncompliance

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		Adequacy of Current Neurology Resources The record request for the schedule of the consulting neurologist noted the neurologist comes to MSSLC once a month, generally on a Monday. Clinic dates submitted to the monitoring team began in December 2012, none were provided for October or November. For the majority of these clinics there were 20-30 minute timeframes beginning at 1:00 pm that allowed minimum allowance for the discussion between the neurologist, psychiatrist, and IDT. 5/29/13 the clinic allowed an hour for each of the four individuals evaluated. Some of the individuals were evaluated by outside providers for neurological care (e.g., Scott and White physicians, Dr. Kirmani, Dr. Keyser, Dr. Ritch, Dr. Borucki). The monitoring team determined that 33% of those enrolled in psychiatry clinic required an IDT review for consideration of a neuropsychiatric evaluation. The psychiatrists did not consistently know if the AED indication was only for the seizure disorder as opposed to prescribed to treat both seizures and a mental health disorder. These individuals require ongoing review through the IDT process, especially when there is a change in status, such as increased frequency of seizures, the addition of another AED and/or removal of an agent, with resultant change in psychiatric presentation. The awareness by the IDT/psychiatrist was imperative in these scenarios in order to work with the neurologist and discourage prescription of a psychotropic medication known to further lower the individual's seizure threshold. The neuropsychiatric evaluation can be one of the QPMRs if completed satisfactorily 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. The drug regimen and drug interactions require a thorough review, particularly for individuals with intractable epilepsy, and how these variables affect the mental status presentation. The medical director informed the monitoring team that he explained the details of this provision item to the consulting neurologist. 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 for individuals with epilepsy (i.e., prescribed solely for purpose of psychiatry). 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.	

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		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 both of these medications also target seizures. Thus, the psychiatrist should obtain consultation with the IDT, including the neurologist, prior to discontinuation of any 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). <u>Monitoring Team's Compliance Rating</u> 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 through the IDT process).	

Recommendations:

1. The facility must have access to 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. Face-to-face consultation contact and/or telemedicine consultation was 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 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. 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 psychiatry and psychology departments (J2, J3, J4, J8, J9).

4. 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 psychiatric clinical indicators to determine the efficacy of the prescribed medication. (J2, J8, J13).

5. 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.

6. 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).

7. 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).

8. Ensure that the clinical indicators/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication were appropriate (J2, J8, J13).
    a. If DSM diagnosis was met, utilize medication 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.

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

10. Regarding the addition of a medication or a medication dosage change, documentation outlining psychiatric target symptoms for each psychotropic medication prescribed 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).

11. 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).

12. 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).

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

14. The facility to maintain a list of individuals requiring a psychiatric evaluation following a positive Reiss Screen or following a change in psychiatric, behavioral, and/or medical status (J7).

15. The facility to address the deficits as outlined in the report regarding informed consent process for psychotropic medications (J14).

16. 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 psychiatric 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).

17. The psychiatrist should utilize the findings obtained via the polypharmacy review committee and the QDRR 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 given (J11, J13).

18. The facility must consider options for implementing neuropsychiatric clinic consultation. It would be beneficial to determine the amount of clinical neurology and psychiatry time needed via an examination of the number of individuals requiring review when prescribed medication to treat both seizures and a mental health disorder. It would be helpful for the facility to learn how other centers are addressing necessary interaction between psychiatry and neurology to implement appropriate clinical care (e.g., monthly neuropsychiatric clinic) (J15).

19. To adequately complete self-assessments, collect data such as number and percentage of meetings attended by the psychiatric staff (i.e., ISPs, ISPAs, PBSPs reviewed in the QPMRs, 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).

20. 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:** Documents Reviewed: o Positive Behavior Support Plans (PBSPs) for: • Individual #142 (2/13/13), Individual #8 (3/7/13), Individual #331 (2/1/13), Individual #383 (11/15/12), Individual #483 (1/17/13), Individual #715 (5/6/13), Individual #462 (3/20/13), Individual #990 (1/16/13), Individual #157 (4/10/13), Individual #321 (2/5/13), Individual #508 (2/20/13), o Functional Assessments for: • Individual #142 (12/27/12), Individual #8 (1/10/13), Individual #331 (1/10/13), Individual #383 (11/12), Individual #483 (1/26/13), Individual #410 (12/12/12), Individual #588 (12/11/12), Individual #366 (2/6/13), Individual #595 (11/20/12), Individual #508 (1/20/13) o Six months of progress notes for: • Individual #142, Individual #8, Individual #331, Individual #383, Individual #483, Individual #462, Individual #990, Individual #157, Individual #321, Individual #508 o Full Psychological Assessments for: • Individual #926 (3/28/13), Individual #991 (4/4/13), Individual #816 (3/26/13), Individual #782 (2/15/13), Individual #798 (2/12/13), Individual #994 (2/12/13), Individual #610 (1/23/13), Individual #657 (1/23/13), Individual #152 (12/13/12), Individual #455 (1/15/13) o Annual Psychological updates for: • Individual #188 (3/25/13), Individual #198 (3/8/13), Individual #366 (2/12/13), Individual #371 (2/2/13), Individual #8 (1/17/13), Individual #560 (1/15/13), Individual #70 (1/14/13), Individual #483 (12/26/12), Individual #142 (12/10/12), Individual #449 (12/10/12) o STARS-Group Counseling treatment plans and progress notes for: • Individual #195, Individual #90, Individual #105, Individual #121, Individual #951, Individual #401, Individual #926, Individual #267, Individual #325, Individual #475, Individual #329, Individual #350, Individual #817, Individual #575, Individual #17, Individual #510, Individual #451, Individual #468, Individual #424, o STARS-Individual Counseling treatment plans and progress notes for: • Individual #253, Individual #462, Individual #470, Individual #219 o Abbreviated Behavior Support Plan for Individual #605, 4/30/13 o Data project presentation, undated o A list of training conducted on PBSPs, undated 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 List of all individuals receiving counseling, undated o STARS Committee organizational manual, 3/27/13 o Stars group attendance graph, Oct 12-May 13 o List of all individuals with a PBSP, undated o Positive Behavior Support Plans at MSSLC reading level, undated o List of the dates of implementation and date of consents of all PBSPs, undated o Minutes of peer review committee meetings for the past six months o Psychology BSP Competency Training Sheet, undated o Section K presentation book, undated o Section K self-assessment, 5/17/13 o Section K action plan, 5/17/13 o Competency based training form, undated o Quality Assurance report, March, April, & May 2013 o Integration of Psychiatry/Psychology meeting agenda, 6/6/13 o Graph of mean reading level for PBSPs, August 2011-April 2013 o Data based treatment decisions monitoring form, 4/21/13 <u>Interviews and Meetings Held</u>: o Charlotte Kimmel, Ph.D., Director of Psychology o Lupita Alfaro, Psychology Assistant o Psychology Department o Andrew Griffin, Psychologist o Polly Bumpers, John Parks, Troy Miller, Bertha Allen, and Rodney Price, Unit Directors <u>Observations Conducted</u>: o Behavior Therapy Committee Meeting • Individuals Presented: Individual #10, Individual #398, Individual #754, Individual #228, and Individual #468 o Anger management group therapy session • Staff facilitators: Richard Boyer, Psychologist; Jeania Doman, Psychology Assistant • Individuals participating: Individual #591, Individual #309, Individual #225, and Individual #157 o Clinical Psychology/Psychiatry Meeting Charlotte Kimmel, Psychology; Andrew Griffin, Psychology; Xiaodong Zhang, Psychology; Temora Gray, Psychology; Kendall Brown, Psychiatry; Madhu Rao, Psychiatry; Juanita Kirby, Psychiatry; Prakesh Shet, Psychiatry o Internal Peer Review Meeting • Staff Present: Michael Miller, Psychologist; Ray Matthieu, BCBA; Nedra Francis, Psychologist; Xiaodong Zhang, Psychologist; Elizabeth Kadin, Psychologist; Tonya Russell, Psychologist; Charlotte Kimmel, Director of Psychology Services, Andrew Griffin, Psychologist; Amy Dillree, BCBA-D, Lupita Alfaro, Psychology Assistant, Molly

	Chase, BCBA, Ora Davis, BCBA; Zuselle Quiles, Psychologist, Brooke Edwards-Williams, Psychologist; Temora Gray, Assistant Director; Celeste Leinberger, Psychologist; Donna Porter, Psychologist; Dr. Brown, Psychiatrist • Individuals Presented: Individual #10, Individual #494, Individual #63 o STARS Task Force Meeting • Lupita Alfaro, Psychology Assistant; Richard Boyer, Stars Program Director; Andrew Griffin, Psychologist; Lisa Jones, Psychology Assistant; Charlotte Kimmel, Director of Psychology Services; Jessica Patton, Psychologist; Craig Biggar, Psychologist; Zuselle Quiles, Psychologist o Psychiatric Clinic • Psychiatrist: Dr. Brown • Individual presented: Individual #6 o Positive Behavior Support Plan Training • PBSP for: Individual #605 • Staff conducting the training: Martha Mason, doctoral intern in psychology o Psychiatry Clinic • Psychiatrist: Dr. Rao • Individuals presented: Individual #331, Individual #64 o Data Project Presentation • Staff present: Amy Dillree, BCBA-D; Charlotte Kimmel, Director of Psychology Services; Lupita Alfaro, Psychology Assistant; Michael Miller, Psychologist; Ray Mathieu, BCBA; Molly Chase, BCBA; Jessica Patton, Psychologist; Ora Davis, BCBA; Temora Gray, Assistant Director; Megan Baker, Psychology Assistant 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, the self-assessment was an improvement over past self-assessments and included relevant activities in the "activities engaged in" sections. Generally, the self-assessment appeared to be based on the monitoring team's report. MSSLC's self-assessment consistently included a review for each provision item, a list of the activities engaged in by the monitoring team. It also included some of the topics that the monitoring team commented in the previous report. This allowed the psychology department and the monitoring team to ensure that they were both focusing on the same issues in each provision item, and that they were using comparable tools to measure progress toward achieving compliance with those issues. The monitoring team wants to acknowledge the efforts of the psychology department in completing the self-assessment, and believes that the facility continued to proceed in the right direction. MSSLC's self-assessment indicated compliance for items K2, K3, and K8. The monitoring team's review of

	this provision found K2, K3, K8, and K11 to be in substantial compliance. The reasons for this discrepancy for K11 are discussed below. Finally, 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 discussed in detail in this section of the report.
	Summary of Monitor's Assessment: Improvements since the last onsite review included: • Improvement in the numbers of psychologists with certification as applied behavior analysts (K1) • Development of a project to ensure that all data are recorded in a timely fashion, data are reliable, and PBSPs are implemented as written (K4, K10) • Increase in the number of new functional assessments (K5) • Improvement in the comprehensiveness of the functional assessments (K5) • Increase in the number of individuals with an annual psychological assessment (K7) • Increase in the comprehensiveness of the annual psychological assessments (K7) • Improvement in the quality of PBSPs (K9) • Improvement in DCP's report that they understood PBSPs (K11) The monitoring team suggests that the facility focus on the following areas during the next six months: • Ensure that all psychologists that write PBSPs have completed or are enrolled in training to obtain their certification as applied behavior analysts (K1) • Reinitiate the collection of interobserver agreement (IOA) (K4) • Increase the flexibility of the system for collecting both target and replacement data (K4) • Establish minimal frequencies of data collection reliability and IOA collection, and demonstrate that those frequencies of data collection are achieved (K4, K10) • Establish minimal acceptable data collection reliability and IOA levels, and demonstrate that those levels are achieved (K4, K10) • Ensure that all individuals with PBSPs have monthly progress notes (K4) • Ensure that the progress note consistently indicates that some activity (e.g., retraining of staff, modification of PBSP) had occurred in those instances when an individual is not making the progress expected (K4) • Increase the percentage of current functional assessments completed for individuals with PBSPs (K5) • Increase the percentage of individuals with annual psychological assessments (K7) • Ensure that all Positive Behavior Support Plans (PBSPs) 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 reasonable safety, security, and freedom from undue use of restraint.	There were improvements in this provision item, however, it was rated as being in noncompliance because 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, three (23%) of the 13 psychologists that wrote PBSPs were BCBAs. This represented an improvement from the last review when one psychologist that wrote PBSPs was certified as an applied behavior analyst. Additionally, 11 of 13 psychologists who wrote PBSPs (85%) were either enrolled, or completed coursework, toward attaining a BCBA. This represented another improvement from the last review when 71% of the psychologists that wrote PBSPs were either enrolled in, or completed, BCBA coursework. The facility should ensure that all psychologists that write PBSPs have BCBAs. The facility provided supervision of psychologists enrolled in the BCBA program by contracting with a consulting BCBA from the community, and by using the BCBAs in the psychology department. MSSLC and DADS are to be commended for their efforts to recruit and train staff to meet the requirements of this provision item. The facility developed a spreadsheet to track each psychologist's BCBA training and credentials.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility continued to be in substantial compliance with this item. MSSLC employed a director of psychology with a Ph.D., certification in sex offender treatment and forensic evaluations, and over 30 years experience working with individuals with intellectual disabilities. Additionally, 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 new cases or those that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #10's, Individual #63's, and Individual #494's PBSPs. 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 environmental and biological variables affecting their target behaviors.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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. Finally there was evidence of the implementation of recommendations made in peer review. Operating procedures for both internal and external peer review committees were established and were consistent with this provision item. There was evidence (i.e., PBSP modifications) that suggestions made in the peer review were implemented. In order to maintain substantial compliance, MSSLC needs to provide documentation that internal peer review consistently occurred weekly, external peer review consistently occurred at least monthly, and evidence of follow-up/implementation of recommendations made in peer review.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The monitoring team noted improvements in this provision item. In order to achieve substantial compliance, however, the facility needs to ensure that the data collection system is flexible, interobserver reliability (IOA) is collected for every PBSP, acceptable IOA frequencies and levels are established, and those frequencies and levels are achieved. Similarly, acceptable data collection reliability frequencies need to be established, and established data collection frequencies and levels need to be achieved. The facility also needs to provide monthly progress notes for all individuals with a PBSP, and ensure that the progress notes consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred when individuals are not making expected progress. Finally, all treatment decisions need to be data based. At the time of the onsite review, MSSLC utilized a 60-minute target and replacement behavior data system for the majority of individuals. This system was modified to recording target and replacement behaviors once a shift for some individuals residing on the Martin unit. As discussed in the last review, 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. Arbitrarily reducing the number of measurement intervals of target and replacement behaviors, however, could result in the loss of critical information. It is recommended that MSSLC ensure that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors. At the time of the onsite review, the facility had begun to investigate the use of a simplified, and potentially more flexible, data system (see the description of the MSSLC's data project below).	Noncompliance

#	Provision	Assessment of Status	Compliance
		In the current 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 (i.e., collect data collection reliability). 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 target and replacement behaviors sampled for nine of 13 data sheets reviewed (69%) were completed up to the previous hour. These results were identical to that found in the last review. MSSLC had recently begun a review and revision of their data system in order to ensure that data across the facility are recorded in a timely manner (i.e., data collection reliability), are reliable (i.e., IOA), and that PBSPs are implemented as written (i.e., treatment integrity). The pilot program began with improving data collection reliability. At the time of the onsite review, several interventions to improve data collection reliability were being investigated. Preliminary data presented to the monitoring team indicated that a modification to the data sheet resulted in the largest improvement in the timely recording of data. At this point, it is recommended that the facility expand the modified data sheets to all treatment sites. Additionally, the facility needs to establish the minimum frequency that data collection will be recorded. The self-assessment indicated that the facility established 80% as the minimum data reliability level acceptable (i.e., what are acceptable data collection reliability scores). Finally, MSSLC needs to ensure that those frequencies and levels are achieved. While data collection reliability assesses whether data are recorded in a timely fashion, IOA assesses if multiple people agree that a target or replacement behavior occurred. At the time of the onsite review, the facility had suspended the collection of IOA, and planned to reintroduce it as part of the data project described above. It is recommended that MSSLC ensure that IOA is collected for each PBSP. Additionally, the facility should establish the minimal acceptable frequency of IOA collection, establish specific IOA goals (i.e., how high does IOA need to be), and ensure that these frequencies of IOA collection and levels are attained. As indicated in the last report, all the graphs of target and replacement behaviors 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.	

#	Provision	Assessment of Status	Compliance
		MSSLC recently introduced the data based treatment decisions monitoring form, to monitor and improve the use of data based decisions in treatment meeting. A member of the psychology department was sampling meetings and noting if treatment data were presented. During the onsite review, however, the routine use of data to make treatment decisions continued to have room for improvement. In both of the psychiatric clinics observed, simplified graphs of target and replacement behaviors were presented and discussed, however, the data did not include the last four weeks of data. Current graphed data are very important for ensuring data based decisions. This was most evident in Individual #64's clinic meeting. He had a recent increase in dangerous behaviors, but because there were no current data, the treatment team identified an intervention based on their perceptions of his recent behavior. In order to achieve substantial compliance with this provision item, MSSLC 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. Six months of PBSP progress notes were requested for 10 individuals and, although all had some progress notes, nine (Individual #383 was the exception) were incomplete (i.e., they contained only one to four monthly notes in a six month period). All individuals with PBSPs should have monthly progress notes. In reviewing at least six months of PBSP data of severe behavior (e.g., physical aggression, self-injurious behavior) for the 10 individuals with progress notes, four (Individual #331, Individual #483, Individual #157, and Individual #508), or 40%, indicated no obvious improvement in severe behavior. This represented an improvement from the last review when 56% of the individual's reviewed showed no obvious improvement in severe behavior. Additionally, there was some indication that when progress was not occurring, action was taken to address the lack of progress. For example, progress notes indicated that Individual #331 and Individual #508 PBSPs were modified, and Individual #483's medications were adjusted to address lack of progress. It is recommended that in those instances when an individual is not making expected progress, that the progress notes consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred. 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 is encouraged by the planning and thoroughness that had gone into the development of the data project at MSSLC, and look forward to seeing the improvements in the data systems at the next onsite review.	

#	Provision	Assessment of Status	Compliance
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.	There have been improvements in this provision item. It was rated as being in noncompliance, however, due to the absence of full psychological assessments for each individual, and the absence of functional assessments for each individual with a PBSP. <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 196 of the individuals at the facility had a full psychological assessment. Thirty-three of the 334 individuals at MSSLC at the time of the onsite review were admitted within the previous three months and, therefore, would not be expected to have full psychological assessments. Therefore, the facility had 196 full psychological assessments for the 301 individuals who have been at MSSLC for at least three months (65%). Each individual's record should contain a full psychological assessment that consists of an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status. A spreadsheet of full psychological assessments indicated that 38 were completed in the last six months, and 10 of these (26%) were reviewed to assess compliance with this provision item. Nine (Individual #782 was missing a review of medical) of the 10 full psychological assessments reviewed (90%) 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 a slight decrease from the last review when 100% of the full assessments reviewed were complete. <u>Functional Assessments</u> A list of functional assessments and PBSPs indicated that 75 of the 258 individuals with a PBSP (29%) had a functional assessment. This represented an improvement from the last review when 17% of individuals with a PBSP had a functional assessment. Only 36 of those 75 functional assessments (i.e., 14% of individuals with a PBSP), however, were current (i.e., revised/reviewed within one year). All individuals with a PBSP should have a current functional assessment of the variable or variables affecting their target behaviors.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A list of all functional assessments indicated that 31 were completed in the last six months. Ten of those functional assessments (32%) 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 10 of the functional assessments reviewed included acceptable indirect and direct assessment procedures. This represented an improvement from the last review when 67% of direct observation procedures were judged to be acceptable. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. This is consistent with the last report when all functional assessments included potential antecedents and consequences. As discussed in the last report, when comprehensive functional assessments are conducted, there are going to be some variables identified that are determined to not be important in affecting the individual's target behaviors. An effective functional assessment needs to integrate these ideas and observations from various sources (i.e., direct and indirect assessments) into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. All 10 of the functional assessments reviewed (100%) were judged to have a clear summary statement. This represented another improvement from the last review when 67% were found to have a clear summary statement. There was no evidence that functional assessments at MSSLC were reviewed and modified when an individual did not meet treatment expectations. As discussed above, 39 of the 75 functional assessments 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. All 10 of the functional assessments reviewed (100%) were evaluated to be comprehensive and clear. This represented a dramatic improvement over the last report when only 33% of the functional assessments reviewed were evaluated as acceptable.	

#	Provision	Assessment of Status	Compliance
		MSSLC made much progress in this provision item by significantly improving the quality of the functional assessments. It is recommended that, over the next six months, the facility now focus on increasing the percentage of individuals with a PBSP that have a current functional assessment.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	MSSLC's 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 68 of the 196 (35%) were not conducted in the last five years. This represented an improvement from the last report when 56% of the full psychological assessments were more than five years old. 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.	There were improvements in both the quality and the number of annual updates completed. This item was rated as in noncompliance, however, because not all individuals who have resided at the facility at least one year had an annual psychological assessment. 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. At the time of the onsite review, 274 of the 334 individuals at MSSLC had been at the facility at least one year and, therefore, should have an annual update. Annual psychological assessments (updates and risk evaluations) were completed for 102 of these 274 individuals (37%). This represented a sharp improvement from the last two reviews when 5% and 13% of individuals had annual psychological assessments. Fifty-three annual assessments were completed since the last review and 10 (19%) were reviewed by monitoring team to assess their comprehensiveness. All 10 annual updates reviewed were judged to be complete containing 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. This represented another significant improvement from the last review when 50% of the annual assessments were complete.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In order to achieve compliance with this provision item, all individuals who have resided at the facility for at least one year will need to have a complete annual update.	
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.	The facility continued to be in substantial compliance with this item. As discussed in the last review, multiple individual and group therapies were offered at MSSLC. At the time of the onsite review, 193 individuals were receiving psychological services other than PBSPs. Twenty-three treatment plans (12%) were reviewed to assess compliance with this provision item. Additionally, the monitoring team observed a group therapy session and attended the STARS task force meeting. 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 the group therapy session indicated that there were clear objectives for the observed session, measurable progress toward those goals were recorded, and the therapy reflected evidence-based practices. Staff who provided therapeutic interventions were qualified to do so through specialized training, certification, or supervised practice. Staff who assisted in therapy, or received training and monitoring from qualified therapists. Finally, the facility developed a referral system and reviewed individuals referred for counseling during the monthly STARS meeting. 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, objective measures of progress, a fail criterion, and a plan for generalization of skills learned during therapy. 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 practices.	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	Although there were improvements in the overall quality of PBSPs, this item was rated as being in noncompliance because PBSPs were not consistently implemented within 14 days of receiving consent and because the 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 258 individuals at MSSLC had PBSPs. A list of all PBSPs and the date of last revision indicated that 257 (Individual #169 the	Noncompliance

#	Provision	Assessment of Status	Compliance
	the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	exception) of these PBSPs (99%) were current (i.e., revised in the last 12 months). A list that included the date of consent and date of implementation of all PBSPs indicated that 135 (53%) of the PBSPs were implemented within 14 days. The self-assessment indicated that 85% of all PBSPs completed from October through March 2013 were implemented within 14 days, however, review of those data indicated some recording errors that the psychology department was working on resolving for the next review. MSSLC should ensure that PBSPs are implemented within 14 days of receiving necessary approvals and consents. Eleven of the 163 PBSPs completed in the last six months (7%) were reviewed to evaluate compliance with this provision item. All 11 of the PBSPs reviewed had the necessary consent and approvals. All PBSPs reviewed (100%) included operational descriptions of target and replacement behaviors. This represented an improvement from the last review when 91% of PBSPs reviewed included operational definitions of target and replacement behaviors. Ten of the 11 PBSPs (91%) reviewed described antecedent and consequent interventions to weaken target behaviors. Individual #331's PBSP included interventions to prevent his target behaviors, but no interventions following the occurrence of target behaviors. All PBSPs should include antecedent and consequent interventions to weaken target behaviors. 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. Individual #990's PBSP, however, did not include a hypothesized function of the target behaviors, so it was not possible to determine if his interventions were based on the their function. Additionally, three PBSPs (i.e., Individual #142, Individual #8, and Individual #508) of the nine that included a function and a consequent interventions (33%) 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 three reports when 27%, 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 #142's PBSP hypothesized that the function of his physical aggression was primarily to attain staff attention. Individual #142's PBSP stated that following the aggressive behavior staff should discuss a positive solution to his problem. If, however, gaining access to staff attention was reinforcing for Individual #142 and the primary reason he engaged in physical aggression (as hypothesized in the PBSP), then this intervention would likely increase the likelihood of his undesired behaviors. Encouraging him to discuss a better solution to his problem or what is bothering him BEFORE he engaged in the	

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		aggression, or when he was calm and no longer engaging in the physical aggression, would potentially be an effective interventions (because he would be receiving staff attention in the absence of the targeted behaviors). When the physical aggression is occurring, however, staff should be instructed to ensure that they provide minimal attention necessary to maintain safety. 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 #157's PBSP hypothesized that his aggressive behavior functioned to gain other people's attention (positive reinforcement) and to escape undesired activities (negative reinforcement). Antecedent interventions included providing him with staff attention when he was exhibiting appropriate behaviors, and encouraging/reinforcing him for engaging in his replacement behaviors (i.e., encouraging him to discuss his problem/concern, praising him for following instructions, etc.). His intervention following physical aggression included minimizing staff attention (asking him once to use his coping skills) until the aggression ended and he demonstrated calm behavior. Additionally, to address the hypothesized negative reinforcement component, his intervention included that staff should continue to present the task he was working on when he engaged in targeted behaviors. Replacement behaviors were included in all of the 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 could not evaluate if Individual #990's replacement behavior was functional because the hypothesized function of his target behaviors was not discussed. Replacement behaviors were found to be functional (when possible) for all of the remaining 10 PBSPs reviewed (100%). This represented a sharp improvement from the last report, when 55% of all replacement behaviors that could be functional were functional. When the replacement behavior requires the acquisition of a new behavior, it should be written as a skill acquisition plan (see S1). If, however, the replacement behavior is currently in the individual's behavioral repertoire (as appeared to be the case in the majority of PBSPs reviewed), the replacement behavior does not need to be written in the skill acquisition plan (SAP) format. Replacement behaviors are an area ripe for collaboration with SLPs and the communication/language department. As noted in section R1 of this report, 4 of 9 PBSPs	

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		in that sample (44%) included some communication strategies recommended in the communication assessment. Section R1 also points out that an SLP attended BTC about half of the time. Overall, seven (Individual #383, Individual #483, Individual #715, Individual #462, Individual #157, Individual #321, and Individual #508) of the 11 PBSPs reviewed (64%) represented examples of complete plans that contained operational definitions of target behaviors, functional replacement behaviors (when possible and practical), and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented an improvement from the last review when 45% 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.	This item was rated as being in noncompliance because IOA and treatment integrity were not being collected at the time of the onsite review. Additionally, for substantial compliance with this item, MSSLC needs to establish and attain minimal acceptable frequencies and levels of IOA and treatment integrity collection. At the time of the onsite review, the facility had suspended the collection of IOA. The collection of IOA was planned to be reinitiated as part of the new data project described in K4. Once IOA is collected for each PBSP, minimum acceptable frequencies and levels (i.e., how high does IOA need to be) of IOA will need to be established. The facility will need to demonstrate that these frequencies and levels were attained. All of the DCPs asked about PBSPs indicated that they understood them (see K11). The most direct method, however, to ensure that PBSPs are implemented as written is to regularly collect treatment integrity data. MSSLC was not assessing treatment integrity of the PBSPs at the time of the onsite review. It is recommended that the facility ensure that treatment integrity is collected for each PBSP, that minimum acceptable frequency of treatment integrity collection is established, and specific treatment integrity goals (i.e., how high does treatment integrity need to be) are established. Finally, MSSLC needs to ensure that these frequencies of treatment integrity data collection and levels are attained. Target and replacement behaviors were consistently graphed monthly at MSSLC. As discussed in K4, the quality and usefulness 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

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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.	All of the PBSPs reviewed appeared simple, clear, and allowed for staff understanding. Additionally, all DCPs interviewed, indicated that they understood the PBSPs. Therefore, this provision item was rated as being in substantial compliance. MSSLC utilized an abbreviated behavior support plan that was located in the individual books, and was written so that DCPs could understand them. As an objective measure of the readability, MSSLC monitored the reading level (using the Flesch-Kincaid Readability score) of all abbreviated PBSPs written from October 2012 to March 2013 and determined that they averaged an 8.0 reading level, compared to a 9.24 reading level reported in the last review. Additionally, review of the PBSPs indicated that they were written in a manner that DCPs were likely to understand. The abbreviated PBSPs reviewed, for example, were consistently brief and concise, contained fewer than four target behaviors, and technical language appeared to be kept at a minimal. Finally, the monitoring team also asked several DCPs across all treatment sites if they could understand the PBSPs, and all DCPs indicated that the plans were simple, clear, and easy to understand.	Substantial Compliance
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 item was rated as being in noncompliance because, at the time of the onsite review, MSSLC did not have documentation that every staff, including relief and float, assigned to an individual was trained on his or her current PBSP. As reported in the previous review, MSSLC 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. The monitoring team observed the training of DCPs on Individual #605's PBSP. The training included a review of the PBSP by the psychologist that wrote the PBSP, an opportunity for DCPs to ask questions, and written questions pertinent to Individual #605's PBSP. The monitoring team found the training to be thorough. Psychology staff indicated that they believed that the facility had documentation that all regularly scheduled staff implementing PBSPs had been trained. They indicated, however, that it was unlikely that psychology staff trained all float/relief staff that have implemented PBSPs. 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/relief staff, has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter.	Noncompliance

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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 334 individuals and employed 13 psychologists responsible for writing PBSPs. Additionally, the facility employed nine psychology assistants and six psychology technicians. Three 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 12 psychologists with BCBAs.	Noncompliance

Recommendations:

1. All psychologists that write PBSPs should have BCBAs (K1).
2. Ensure that the data system is flexible (K4).
3. Expand the modified data sheets to all treatment sites (K4).
4. Establish the minimum frequency that data collection reliability will be recorded, and ensure that established frequencies and levels are achieved (K4).
5. Ensure that IOA is collected for each PBSP (K4).
6. Establish the minimal acceptable frequency of IOA collection, establish specific IOA goals (i.e., how high does IOA need to be), and ensure that these frequencies of IOA collection and levels are attained (K4).
7. Ensure that all treatment decisions are data based (K4).
8. All individuals with PBSPs should have monthly progress notes (K4).
9. In those instances when an individual is not making expecting progress, the progress note should consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4).
10. Each individual's record should contain a full psychological assessment that consists of an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status (K5).
11. All individuals with a PBSP should have a current functional assessment of the variable or variables affecting their target behaviors (K5).

12. 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).

13. All individuals who have resided at the facility for at least one year should have a complete annual update (K7).

14. Ensure that PBSPs are implemented within 14 days of receiving necessary approvals and consents (K9).

15. 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).

16. Ensure that treatment integrity is collected for each PBSP (K10).

17. Establish the minimum acceptable frequency of treatment integrity collection, establish specific treatment integrity goals (i.e., how high does treatment integrity need to be), and ensure that these frequencies of treatment integrity collection and levels are attained (K10).

18. The facility needs 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 (K12).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009.2: Medical Care, 5/15/13 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 Pneumonia Review Notes o Clinical Daily Provider Meeting Minutes, 2/27/13 - 3/28/13 o Medical Review Committee Meeting Minutes, March 2013 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 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 #538, Individual #587Individual #314, Individual #61, Individual #577 Individual #407 Individual #600 Individual #493 Individual #881 o Annual Medical Assessments the following individuals: • Individual #536, Individual #386, Individual #268, Individual #253, Individual #288, Individual #261, Individual #505, Individual #236 Individual #276, Individual #62, Individual #34, Individual #2, Individual #266 Individual #454, Individual #188 o Neurology Notes for the following individuals: • Individual #512 Individual #511, Individual #175, Individual #524 Individual #452, Individual #557, Individual #109 o Consultation Referrals and IPNs and for the following individuals: • Individual #614, Individual #502, Individual #395, Individual #524 <u>Interviews and Meetings Held</u>: o Christopher Ellis, MD, Medical Director o James Gilley MD, Primary Care Physician o Admerle Hoskins, DO, Primary Care Physician o Michael Meyerson, MD, Primary Care Physician o Kendall Brown MD, Staff Psychiatrist o Madhu Rao MD, Staff Psychiatrist o Juanita Kirby, MD, Staff Psychiatrist o Prakash Shet, Staff Psychiatrist o William Thomas, PA o Angela Johnson, RN, Medical Compliance Nurse o Norris Buchmeyer, Chief Nurse Executive <u>Observations Conducted</u>: o Daily Clinical Services Meetings o Medical Review Committee Meeting 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 brief. For each of the four provision items, it listed one to four activities engaged in to conduct the self-assessment. For L1, the self-assessment documented the following: • AMAs and QMSs were reviewed from 12/1/12 to 3/30/13 to determine if they were adequately addressing the individuals' health care needs. It was reported that 92% of the AMAs and QMSs reviewed adequately addressed the health care needs of the individuals. However, the self-assessment did not indicate who completed the reviews, the criteria for review or the number of assessments reviewed. • The IPNs for acute care from 12/1/12 to 3/30/13 were reviewed to determine if the format was appropriate and follow-up was adequate. It was reported that 95% were in appropriate format, but there was no comment on the compliance with timeliness and appropriateness of follow-up • Records were reviewed from 12/1/12 to 3/30/13 to determine if preventive care screenings, such as those for cancer were provided as recommended. The self-assessment reported a very vague finding that 82% of cancer preventive screenings have been provided. Overall, the self-assessment for provision L1 will require additional work. The scope of this provision item is broad as it assesses the overall provision of medical care. Thus, the monitoring team evaluates structural, process and outcome indicators. In addition to medical care, staffing, ancillary, and consultative services are also assessed. Completion of through self-assessment will require looking at more of the items reviewed by the monitoring team. 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 leadership within the medical department had changed since the last compliance review. The new medical director had been in his position for six months prior to the review. He had worked at the facility for four years and was, therefore, familiar with the daily operations of the medical department and the facility. He was aware of the numerous challenges that faced the department, including the significant concern of medical staff turnover. The medical director had not had sufficient time to address the numerous issues that required attention. He maintained a caseload, so this decreased the overall time that could be devoted to management issues. Nonetheless, it was apparent that several long term problems were beginning to show improvement. The basic health care services were provided to the individuals at MSSLC. The routine screening exams and vaccinations were provided with high rates of compliance. Compliance with cancer screenings showed

	improvement and was quite good. For those individuals who did not complete the screenings, there was usually an explanation. Overall, documentation in the records had improved. Annual Medical Assessments were completed in a timely manner. The documentation of consultations was also much improved. Notwithstanding the improvements, there were many areas that required additional work. Follow-up of medical issues was a concern, particularly following hospitalization. Several individuals had recurrent pneumonia and were reviewed by the Pneumonia Review Committee. The records did not always indicate a clear plan of care and follow-up of important issues. The facility had not addressed the development of a medical quality program and was not tracking data related to this. There was evidence that steps were taken to improve quality and compliance with the various guidelines and protocols. No new policies or procedures were developed since the previous compliance review and many of the state issued guidelines needed to have local policies developed. Finally, there were challenges in completing this review. Some records were not provided and one was missing many sections, including the health data. Labs, Quarterly Drug Regimen Reviews, and other documents were not copied for several of the records in the sample.

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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, four locum tenens physicians, and one physician assistant. The average caseload was 73 with the largest being 93. The largest caseload of 93 belonged to the medical director who provided care to the most medically fragile and sickest individuals residing at MSSLC. The physician assistant and medical director worked together to provide care to those individuals. An adequate agreement was in place between the physician assistant and the medical director. The medical program compliance nurse was in the process of transitioning to a new position. **Physician Participation In Team Process** The facility continued the daily 8:30 am clinical services meetings. The medical director	Noncompliance

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		facilitated these meetings, which were attended by the medical staff, multiple department heads, and other key staff. The meeting was brief, lasting approximately 30 minutes. It covered events that occurred throughout the facility over the last 24 hours. 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. Minimal data were submitted to the monitoring team. The data essentially showed that for the months of January 2013 - April 2013, on average, the medical providers attended 17% of the annual ISPs. While the primary providers are not core members of the IDT, a lack of attendance by primary medical providers at annual planning meetings is a barrier to the integration of clinical services and appropriate delivery of health care services. The primary medical providers play an integral role in the planning process in terms of determining how the individual's health will impact goals, barriers, transitioning, etc. The PCPs will not be able to attend every meeting with the current caseload. This will require that the facility develop a strategy to have improved attendance and participation by the PCPs. The monitoring team reviewed minutes from the daily clinical services meeting. The minutes reviewed documented a variety of issues. However, several documents were simply handwritten notes that were not legible. Other documents included repetitive issues that stated they were being removed or tabled. Minutes were also taken during the Medical Review Committee meeting, which was conducted weekly. The minutes noted that there would be discussion of issues such as APLs, ISP schedules, ADRs review of physician orders, etc., but there was no synopsis of the discussions, outcomes or actions that needed to occur related to any of the issues. The monitoring team noted that many of the issues listed were problematic for the facility. **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. Documentation indicated that clinic did not occur for several months. 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.	

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		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. Generally, the providers addressed the needs of the individuals. Many of the problems observed during the conduct of this review appeared to be related to the lack of continuity of care because of the medical staff turnover and systems that required improvements. **Documentation of Care** The Settlement Agreement sets forth specific requirements for documentation of care. The monitoring team reviewed numerous routine and scheduled assessments as well as record documentation. The findings are discussed below. Examples are provided in the various subsections and in the end of this section under case examples. <u>Annual Medical Assessments</u> 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 9 (100%) AMAs were completed in a timely manner • 4 of 9 (44%) AMAs included comments on family history • 7 of 9 (77%) AMAs included information about smoking and/or substance abuse history • 0 of 9 (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	

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		Overall, the content of the AMAs had improved over the past two years. Areas that needed improvement were risk identification and management, family history, and the plans of care. The medical staff should consider including a discussion of risk and risk mitigation in the annual summaries. For every active problem, there should be a well defined plan of care rather than a statement such as continue current treatment. The medical department submitted data for the months of January 2013 through March 2013 related to medical assessments. The graphs depicted medical assessments and ISP assessments. The scores for the months of January, February, and March 2013 were 82%, 86%, and 85%, respectively for the medical assessments. The ISP assessments scores, for the same timeframe, were 98%, 90%, and 90%. Interestingly, Round 7 of the external medical audits resulted in a 60% compliance score related to completion of the Annual Medical Assessments. The monitoring team did not find any deficiencies with timelines for AMA completion. <u>Quarterly Medical Summaries</u> The medical department utilized the state issued template for completion of Quarterly Medical Summaries. For the records contained in the record sample: • 4 of 9 (44%) records included at least one QMS in the active record. Compliance with this requirement was quite low and appeared to deteriorate since the last compliance review. It was not clear if the QMSs were not done or were not submitted due to problems with record submission. The monitoring team noted that some QMSs were found in the correct record order, behind the Annual Medical summary while others were included in the IPN documentation. For the QMSs that were reviewed, the content and format were good. The facility provided no specific data related to compliance with this requirement. <u>Active Problem List</u> For the records contained in the record sample: • 8 of 9 (88%) records included an APL Two of the eight APLs were excluded due to copy issues. Some documents did not include recent diagnoses, such as pneumonia. The problem lists should be updated as problems arise and/or resolve. Overall, this area needed significant improvement. <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. Pre-hospital notes were	

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		frequently not found, but many transfers occurred after hours. Post-hospital documentation was problematic. Individuals returning to the facility following hospitalization for serious illness were sometimes seen only once. There was good documentation of the results of diagnostics, such as labs and x-rays and consultation recommendations. Physician Orders Generally, the medical staff did an adequate 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. The record sample as well as sample of physician orders reviewed did show that incomplete orders were sometimes written. This was usually limited to the lack of an indication or stop dates. The monitoring team was concerned about the particular use of the term "when available" being used in many medication orders. This pattern appeared to have increased in recent months and may have been in response to problems related to timing the first dose. This open-ended timing allowed for a great deal of latitude in administering the first dose of a medication. The medical, pharmacy and nursing departments should work together to resolve this problem in a manner other than the use of this terminology. Consultation Referrals The facility utilized the state database to track consults. Consults for four of the five individuals requested were received. A total of 45 consults completed after September 2012 (including those from the record sample) were reviewed: • 35 of 45 (78%) 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. The facility continued to utilize the Providers Review of Recommendations Form. The forms that were reviewed summarized the recommendations, indicated agreement, or disagreement, and documented a decision about IDT referral. However, the forms were inconsistently found in the active records reviewed. The actual IPN documentation usually summarized the recommendations and stated a plan, but did not explicitly state agreement/disagreement or note a decision about IDT referral. 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.	

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		Compliance with cancer screenings improved and explanations were provided when screening was deferred. Preventive care services, such as cancer screenings and osteoporosis, were tracked in databases. Data from the nine record reviews listed above and the facility's preventive care reports (databases) are summarized below: <u>Preventive Care Flow Sheets</u> For the records contained in the record sample: • 6 of 9 (67%) records included PCFSs • 1 of 6 (17%) forms were signed and dated The Preventive Care Flowsheets were not found in all of the records reviewed. The majority of the PCFSs needed updating or completion. Dates of immunizations were not provided and some information that was available was not recorded. There was no indication who completed the form and most forms continued to have additional information, such as labs and diagnostics, scribbled in the margins. Cervical cancer screening for males was listed as contraindicated instead of not indicated. The monitoring team recommends that these documents be updated no less than quarterly as part of the quarterly medical review. If inclusion of additional elements is warranted, the form should be formally revised as opposed writing various diagnostic results in the margins. The forms should be signed and dated in the spaces provided. <u>Immunizations</u> • 9 of 9 (100%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations or had documentation of status • 9 of 9 (100%) individuals had documentation of varicella status. <u>Screenings</u> • 8 of 9 (89%) individuals received appropriate vision screening • 8 of 9 (89%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> • 2 of 5 males met criteria for PSA testing • 2 of 2 (100%) 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: • 52 of 54 (96%) males had current PSA results documented • 2 of 54 (4%) males were overdue for PSA testing	

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		Breast Cancer Screening • 4 of 4 females met criteria for breast cancer screening • 3 of 4 (75%) females had current breast cancer screenings A list of females age 40 and older was provided. The list included the names of 46 females, the date of the last mammogram, and explanations for any lack of testing: • 31 of 46 (67%) females had current breast cancer screenings • 15 of 46 (33%) females did not have current screenings • 11of 46 (24%) females had documentation of explanations for lack of screenings such as refusal, advanced age, etc. Cervical Cancer Screening • 3 of 4 females met criteria for cervical cancer screening • 2 of 3 (67%) females completed cervical cancer screening within three years A list of females age 18 and older was provided. The list included the names of 49 females, the date of the last pap smear, and explanations for lack of testing: • 34 of 49 (69%) females completed cervical cancer screening in 3 years • 10 of 49 (20%) females did not complete due to age • 5 of 49 (11%) females did not complete for other reasons • 11 of 67 (16%) females had no documentation of cervical cancer 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 90 individuals: • 77 of 90 (85%) 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.	

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		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. <u>Pneumonia</u> The facility submitted a list of individuals with the diagnosis of pneumonia between July 2012 and March 2013. Thirty-two individuals on the list had 38 episodes of pneumonia. There were discrepancies between this document and the AVTAR pneumonia list that included differences in the type of pneumonia and dates. Additionally, the pneumonia review committee minutes documented Individual #293 with pneumonia. 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 and review data and develop a disposition. This was good to see because the documentation in the IPNs and Annual Medical Assessments rarely indicated that many important clinical issues relevant to the management of pneumonia were being taken into consideration. Even so, the minutes provided to the monitoring team included several items that were important, but left blank. For example, Individual #407 was hospitalized with pneumonia. Upon return to the facility, a post hospital note was written, but it did not include discussion of the possible causes of aspiration or how to minimize future occurrences of aspiration. Unfortunately, the pneumonia review minutes left the disposition blank as well. Individual #577 had possible aspiration pneumonia in September 2012 and was reviewed by the committee. The minutes indicated the possibility of aspiration and the need for a swallow study was discussed. This issue was to be discussed further with the physician. The MBSS was not completed until January 2013. The facility had additional work to do in the management of pneumonia, but it had the framework necessary to move forward. The risk identification process, the PNMT, and pneumonia review committees all played an integral role in management of one of the most important issues for individuals with developmental disabilities. Overall, the Pneumonia Review Committee appeared to be adequately reviewing information and drawing reasonable conclusions to assist the IDTs in management. The committee may be of further assistance by conducting follow-up on the status of the recommendations made.	

#	Provision	Assessment of Status	Compliance
		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. <u>Osteoporosis</u> • 3 of 9 individuals were diagnosed with osteoporosis • 3 of 3 (100%) individuals received treatment with Vitamin D and/or calcium • 3 of (100%) individuals received additional pharmacologic therapy (Reclast/Alendronate) • 7 of 7 (100%) individuals had documentation of BMD A list of 88 individuals with the diagnosis of osteopenia and osteoporosis was provided. For those 67 individuals with a diagnosis of osteoporosis: • 42 of 67 (63%) individuals received treatment with Reclast • 15 of 67 (22%) individuals received Alendronate • 7 of 67 (10%) individuals received treatment with other pharmacologic therapies • 48 of 67 (72%) individuals completed DEXA scans between 2011 and 2013 • 16 of 67 (24%) individuals had no DEXA scan documented • 3 of 67 (4%) individuals had DEXA scans prior to 2011 The data submitted to the monitoring team appeared incomplete. The individuals with osteopenia had no information provided. **Case Examples** Individual #577 • This individual had multiple medical problems and, unfortunately, several gaps were noted in the care provided. On 4/2/13, a pulmonary note indicated the individual had recurrent aspiration pneumonia likely associated with dementia. A CT scan was requested. A note by the PA documented that this would be discussed with the physician, but no documentation of that discussion was found. • On 5/30/13, the individual fell and hit head. Nursing documentation did not include a history of loss of consciousness. Subsequent nursing entries noted "unable to check pupils." There was no physician notification for this individual who was reported to have minor head trauma and required neurological checks. The individual was seen the following day in clinic. • The AMA dated 8/13/12 for this individual noted with regards to preventive care " for some reason the patient did not get the colonoscopy."	

#	Provision	Assessment of Status	Compliance
		Individual #407 • This individual was hospitalized with Dilantin toxicity after an episode of emesis resulted in aspiration and hypoxia. Following discharge, the post hospital note, dated 10/20/12, did not include any discussion related to the cause of emesis or how future episode of aspiration would be prevented. The next medical entry on 10/30/12 was due to seizure activity. A review of the Pneumonia Review Committee notes also showed no disposition for this individual. • This individual was also transferred to an acute care facility on 9/1/12 due to an apneic episode that was reported to be five minutes. According to the ED documentation, the individual started to breathe, "just as they were about to start CPR." Individual #881 • This individual was evaluated by a primary provider on 4/20/13 and treated with antibiotics for sinusitis and pharyngitis. On 4/22/13, the individual became short of breath and acutely ill. This was associated with ingestion of a peanut butter cookie. The individual was admitted to the hospital with diagnosis of angioedema. • Following discharge, the individual was seen by the MSSLC primary provider and a post hospitalization note was completed. There was no discussion of how to minimize a reoccurrence of a similar event or what, if any, special medical plans were implemented in the case of a future allergic reaction. The history of the peanut butter allergy was documented at admission. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 99 individuals. The listing included medications that were not used for the management of seizure disorder, such as new generation antipsychotics and benztropine. A separate document provided by the facility indicated the following for AED polypharmacy: • 18% individuals received 2 AEDs • 8% individuals received 3 AEDs • 3% of individuals received 4 AEDs • 0% of individuals received 5 AEDs • 32% of individuals received older AEDs, such as mysoline, dilantin or phenobarbital	

#	Provision	Assessment of Status	Compliance
		The number of individuals seen in the on-campus clinic and those seen off campus is summarized in the table. The on-campus clinic was conducted by a general adult neurologist. Off campus appointment occurred with several providers, one of whom was an epileptologist. The medical director indicated that the epileptologist would begin providing services on campus. However, this arrangement was noted to be pending at the previous compliance visit in September 2012 as well.	

Neurology Appointments 2012 - 2013		
	On-Campus	Off-Campus
Oct	0	9
Nov	0	16
Dec	6	3
Jan	6	11
Feb	6	4
Mar	7	6

The medical director will need to review the adequacy of the services provided to determine if any delays are occurring.

The facility reported that 1 (1%) individual had refractory seizure disorder. A review of neurology clinic notes identified several individuals given the diagnosis of intractable seizure disorder by the neurologist. Individual #175, Individual #524, Individual #538, and Individual #407 were all determined to have intractable seizure disorder. No individuals were in the process of being evaluated for VNS implantation. Six individuals were transported to the hospital for uncontrolled seizures. One individual was cited as having status epilepticus, but was not listed as transferred to the hospital. The medical director will need to review the accuracy of the information in the seizure database. It is particularly important to ensure that those with intractable disease are identified and referred to an epileptologist.

The monitoring team requested neurology consultation notes for 10 individuals. These individuals are listed in the above documents reviewed section. The following is a summary of the review of the10 records in addition to the five records included in the record sample:

- 4 of 15 (27%) individuals were seen at least twice over the past 12 months of 15 (60%) individuals had documentation of the seizure description
- 10 of 15 (67%) individuals had documentation of current medications for seizures and dosages
- 11 of 15 (73%) individuals had documentation of recent blood levels of antiepileptic medications
- 6 of 15 (40%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms

#	Provision	Assessment of Status	Compliance
		• 11 of 15 (73%) individuals had documentation of recommendations for medications • 0 of 15 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc. Individuals who were seen at Scott and White by the epileptologist usually returned with a preliminary handwritten note. The official consult was electronically generated. The notes were usually thorough, but documentation varied based on the type of appointment. Medication instructions and follow-up guidelines were usually provided. The following are several concerns based on documentation in the consultation notes: • Several consultations indicated that obtaining data was problematic. For Individual #534, an appointment was essentially lost because the neurologist noted, "The only documentation that came with the patient was a transportation note." • Recommendations for follow-up were not always followed. Individual #577, who had intractable seizures, was seen in clinic on 9/10/12 and was to return in three months. The appointment did not occur until 3/25/13. • The monitoring team also noted that none of the consultations reviewed for those with intractable seizure disorder discussed any treatment options beyond medication management. The neurology notes from campus appointments were very difficult to read. Each note, regardless of appointment type, was limited to less than a half of a page. Legibility of the handwriting was problematic as well. Generally, it would appear the IDTs would require better documentation of the assessment and plan for the individuals. The on campus notes never reflected participation of the IDT and psychiatrist although many appointments were considered neuropsychiatry clinic appointments. In addition to the clinic appointments, scan calls occurred in February and March 2013 with the Scott and White epileptologist. The documentation provided listed seven individuals along with plans such as "tapering Ativan" or "continue present regimen." The information for both calls was essentially identical. **Do Not Resuscitate** During the September 2012 review, the monitoring team pointed out that two of the three DNRs implemented failed to provide clinical justification for the DNRs. There was also no documentation of discussion and review by the IDT or the ethics committee. The facility submitted a list of three individuals with current DNRs. One was implemented since the last compliance review. Each of the three DNRs cited guardian request as the reason for the DNR. For Individual #432, the DNR lacked a guardian signature, but was	

#	Provision	Assessment of Status	Compliance
		signed by two physicians. The facility submitted no clinical justification for the implementation or continued implementation of the DNRs. There was no documentation of the IDT or Ethics Committee review. 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 assistance to facilitate the quality of medical care and performance improvement.	<u>Medical Reviews</u> Round 7 of the external medical audits was conducted March 14-15, 2013 by a physician from Abilene SSLC. State guidelines required that a sample of records be examined for compliance with 30 requirements of the Health Care Guidelines. Twenty records were reviewed for the general medical audits. 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 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. The monitoring team was provided several documents related to the external and internal medical audits. However, key information historically provided, such as the overall compliance with essential and non-essential elements, was not provided. This information was requested, but never received. The facility submitted supplemental information, including the exit comments from the reviewer and compliance by question. The essential and nonessential elements are the two major metrics of the external audits, but were not utilized in the self-assessment, QAQI presentation dated 3/28/13, or PET presentation during the onsite review. The monitoring team is not clear on the value of this information since it does not appear to be utilized during quality activities. Twenty records were reviewed for the general medical audits. The monitoring team was provided each individual audit tool as well as the compliance by question graph for the general medical external audits. Compliance with appropriately completing the APLs was approximately 77%. Completion of the Annual Medical Assessments also proved problematic with a compliance score of 60%. The requirement to document the medical and surgical consultations within five working days met the target with a score of 80%. In addition to the general medical reviews, medical management audits were also completed. For the conditions of diabetes mellitus, osteoporosis, and aspiration pneumonia, three records were reviewed for each condition. The QA reports indicated overall compliance rates of 63%, 80%, and 52 % for management of diabetes, osteoporosis, and pneumonia, respectively. The exit comments from the review	Noncompliance

#	Provision	Assessment of Status	Compliance
		indicated the following: • More documentation was need in regards to risk and precipitating factors for aspiration needs and review of medications that may contribute to aspiration. • The AMAs needed additional discussion related to risk identification and management of diabetes mellitus. The audits also showed 100% compliance with the presence of indications for medication orders. It was not clear if the reviewer based this rating on the presence of the indication on the MAR or the actual physicians' orders. In either case, sample size may have been a contributory factor. Incomplete orders, specifically those lacking indications, were not infrequent at MSSLC. This is discussed in further detail in section N1. Corrective actions were implemented for the observed deficiencies and followed up by the QA department. Data submitted by the QA Department documented that 100% of action plans were completed. The self-assessment dated 5/17/13 noted that 17 action plans were developed, but at that time were not being tracked. 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. There were no initiatives presented to the monitoring team that would address the low compliance scores obtained in the medical management audits. <u>Mortality Management</u> One death occurred at MSSLC in 2012. There were three deaths since the last compliance review. One occurred just prior to the compliance review. Information for the two earlier deaths is summarized below: • The average age of death was 68 years with an age range of 57 to 79 years. • The causes of death were: (1) respiratory failure, pneumonia and sepsis and (2) anoxic brain injury, cardiac arrest, acute hypoxic respiratory failure • No autopsies were performed. • Both individuals died during hospitalization. The monitoring team met with the medical director, chief nurse executive, and QA nurses to discuss mortality management. The discussion, limited by the need for the	

#	Provision	Assessment of Status	Compliance
		medical director to attend another meeting, focused on follow-up of implementation of recommendations. There appeared to be some improvement in the system and a log was maintained that tracked the status of the recommendations. The monitoring team had concerns about the lack of autopsies completed. The record review for one individual stated, "no autopsy requested." There was no documentation in the second record of a request for autopsy for an individual who died because of a choking incident. Another concern was the lack of an objective review. While a community physician participated in reviews, there was no written report of those findings. Moreover, the timeframe for review was limited. It was reported that the Quantros reviews continued, but the recommendations were received many months following the death. 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; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The facility had not developed a formal medical quality program and was not tracking a defined set of clinical indicators apart from those associated with the medical audits and preventive care services. The document request indicated no data were available for the request. However, during the compliance review, the medical director discussed actions taken to help improve preventive care services, such as providing monthly reports of delinquent preventive care services to the medical staff during the medical review committee meeting so that corrective actions could be taken. Committees, such as the Pneumonia Review Committee, had the ability to improve quality by serving as an oversight process related to the management of individuals with pneumonia. Many of the items included in the pneumonia review checklist were indicators found in the state issued pneumonia guidelines and the minutes documented discussion of the issues, although not always to closure. The first steps in establishing a medical quality program must be establishing the program infrastructure, selecting performance measures, and ensuring that staff have knowledge of the process. Equally as important is establishing a solid data management system to ensure that data utilized is valid and reliable. It will also be important to review the work of the various committees to ensure that there is no duplication of efforts. This provision remains in noncompliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	There were no new policies/procedures/protocols developed or implemented concerning additional clinical guidelines since the last compliance review. The facility had localized the state issued medical care policy. The medical director indicated that the clinical guidelines were utilized at the facility, but no local policies were developed based on those guidelines. The use of contract physicians and the subsequent high turnover rate made physician inservicing more complex. As a quick reference, the medical staff were all provided a set of pocket cards that highlighted key issues for the six medical conditions that comprised the medical management audits. MSSLC will need to ensure that all state issues clinical guidelines are implemented. Moreover, local policies must be developed and/or modified to be consistent with state issued policy. It is also important that policies and procedures reflect processes that are implemented and/or changed. Additional clinical guidelines should also be developed based on the individuals served at the facility and the common medical diagnoses. This provision remains in noncompliance.	Noncompliance

Recommendations:

1. The facility must address the issue of medical staffing. There should be ongoing efforts to recruit permanent staff and support the current long-term staff (L1).

2. Primary provider attendance and participation in the annual ISPs must improve. The facility should develop a process for prioritization of PCP attendance that is reasonable based on the current caseloads. Once that is established, the medical staff should be held accountable for participation (L1).

3. The medical director should continue to address the various documentation issues including the timely completion of QMSs, inclusion of family history in the AMAs, updating of the APLs, and legibility of record entries (L1).

4. The Preventive Care Flow Sheets should be signed and initialed when updated by providers. These documents should be updated, minimally on a quarterly basis and should be limited to the required information. The form should be revised if additional information is needed (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 review the data included in the seizure database for accuracy (L1).

7. 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).

8. The medical director should ensure that outside consultants receive all necessary information. Consult requests should be adequately completed and the appropriate data sent with the individual (L1).

9. Individuals with refractory seizure disorder should be referred to a qualified epileptologist (L1).

10. 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).

11. 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)

12. If not already done, the medical director should review the care of Individual #407 to ensure that appropriate procedures related to resuscitation were followed.
13. The external medical audits must include a component to address clinical outcomes (L2).

14. The facility should conduct periodic review of the recommendations generated by mortality reviews. This should be conducted as a formal meeting with the medical director, CNE, QA nurses, medical staff, and representative of the facility director. There should be a periodic review of the plans that were implemented to ensure that they are ongoing and effective (L2).

15. The medical department should develop a process for data validation to ensure that data is valid and reliable (L3).

16. The medical director should continue to expand the set of indicators developed. Indictors 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).

17. 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).

18. The medical director must ensure that all state issued guidelines are localized and implemented and all providers receive information regarding clinical guidelines (L4).

19. 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).

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:** Documents Reviewed: o MSSLC Section M Self-Assessment, updated: 5/14/13 o MSSLC Section M Action Plan, update: 5/14/13 o MSSLC Section Presentation Book o Active Record Order and Guideline o Map of Facility o MSSLC Nursing Services Organizational Chart, including titles and names of staff currently holding management positions o MSSLC Nursing staffing reports last six months o The last six months, minutes from the following meetings: Infection Control, Nurse Manager/Specialty Nursing, Nurse Manager Meetings o MSSLC Nursing On Job Training – Policy & Procedure –assessments o MSSLC RN Case Manager Quick Tips o MSSLC Last six months of LVN staffing reports o Last six months, QA Nurses project reports o Last six months Hospitalizations and ER visits o MSSLC Nursing Policies and Procedures o MSSLC Medication Variances Policy, #53, Implemented: 11/3/11 o MSSLC Medication Variance Report o MSSLC Medication Administration Positioning Training for Nurses Agenda/Training Curriculum o Medication Error Report Form o Last six months, diet/nutritional individual supplemental support plan addendums o Last six months, Infection Control Data Summary, 11/1/12 through 4/30/13 o Real Time Audits for Acute Infections Tool o Guidelines Infection Control, revised: 4/11/12 o Hand washing Monitoring Tool, revised: 1/13/13 o Infection Control Policy Reporting of Infections and Communicable Diseases 10/1/08 o Weekly Infection Report Reporting Form revised: March 2008 o Report of employee infections o MSSLC Emergency Response Policy Implementation date: 10/11/11 o AED & Emergency Bags Locations o Emergency Oxygen Tank and Suction Machine(s) Checklist Exhibit C-SSLC044B Form o Emergency Equipment Daily Checklist Form o Last six months, all code blue/emergency drill reports, including recommendations and/or corrective action plans o Last six months, nursing audits, data, analysis, reports, sample size, staff completing the audits, plans of correction for head injury, vomiting, seizure activity, antibiotic therapy urinary tract infections, acute illness an injury, urgent care/emergency room and hospitalizations, nursing

	infection control, respiratory compromise, chronic respiratory distress, prevention, skin integrity, annual nursing care plans, documentation, pain management; and random monitoring verification o Annual Aspiration Pneumonia/ Enteral Nutritional Evaluations, 11/15/12 through 5/23/12 o MSSLC Comprehensive Nursing Assessment Guide o MSSLC Care and Use of Enteral Feeding Tubes o Preferences and Strengths Inventory (PSI) Individual #398 o Annual, Integrated Risk Rating Form (IRRF) Individual #398 o SSLC Infection Control Committee Guidelines o MSSLC Guidelines for Prevention and Treatment of Altered Skin Integrity NS-58 dated: 5/1/13 o MSSLC Wound Care Tracking by TYPE for each unit o MSSLC Wound Care Tracking by Resolved/Unresolved o MSSLC Wound Care Tracking by Alpha o MSSLC Wound Care Tracking by Diagnosis o MSSLC Martin Mentoring Schedule o MSSLC Mortality Summaries, 6/6/13 o MSSLC Mortality Recommendations for the last six months, 6/6/13 o A list of individuals ever diagnosed with human immunodeficiency virus (HIV), 6/6/13 o A list of individuals diagnosed with Methicillin-resistant Staphylococcus aureus (MRSA), Hepatitis, A, B, and C, positive Purified Protein Derivative (PPD), converts, HINI, Clostridium Difficile (C-Diff) and/or sexually transmitted disease (STD's) including name, unit and date of diagnosis. 6/6/13 o A List of Individuals at Risks 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 Mealtime and Snack Monitoring Policy, 1/1/10 o Mealtime and Snack Integrated Progress Notes and Meal Time Observations conducted Face-to-Face Monitoring by RN Case Managers 2/28/13 -5/2/13 o Universal Monitoring Form –final revised 2013 and 2011 Random Medication Administration o MSSLC M Presentation Book o Medical Records for the following • Individual #80, Individual #98, Individual #349, Individual #188, Individual #597, Individual #414, Individual #521, Individual #432, Individual #285, Individual #460, Individual #296, Individual #211, Individual #314, Individual #35, Individual #518, Individual #593, Individual #494, Individual #237, Individual #519, Individual #115, Individual #38, Individual #493 . <u>Interviews and Meetings Held</u>: o Norris Buchmeyer, RN, BSN, Chief Executive Officer (CNE) o Katrina Erwin, RN, BSN, Nurse Operations Officer (NOO) o Gaby Brewer RN, BSN, Program Compliance Nurse o Phillip Morton RN, BSN, Infection Control Nurse (ICN) o Genia Duke, RN, Nurse Educator o Rosemary Roberts, RN, Nurse Liaison

	o Mitzi Daniel, RN, BSN, RN Case Manager/Supervisor o Karen Wilson RN and Dawn Price RN, Quality Assurance Nurses o Ashley Lathrop RN, Shamrock RN Case Manager o Amy Hill, RN, Shamrock RN Case Manager o Nurse Managers o Staff RN's and LVNs o Craig Burgess, Nutritionist o Jenifer Capers, Licensed Dietician, L.D. o MSSLC Infection Control Meeting 6/3/13 o MSSLC Guidelines for MRSA/Contact o MSSLC Nursing Guidelines/Protocol for Clostridium Difficile (C-Diff) o MSSLC Skin Integrity Committee Meeting, 6/3/13 o Meetings with Nursing Administration and Specialty Nurses 6/4/13 o Meeting Review of Presentation Book, 6/4/13 o MSSLC Clinical Services Morning Meeting, 6/4/13 o Interdisciplinary Team Meeting for Individual: #398, 6/4/13 o Performance Evaluation Team IV Meeting (PET IV), 6/5/13 o MSSLC Medication Administration Meeting (MERC), 6/6/13 o MSSLC Medication Administration Record o Mortality Review, 6/6/13 o Review of systems for scheduling, tracking, and monitoring physician ordered x-ray, consults, and laboratory o MSSLC Medication Variance Committee Meeting, 6/6/13 <u>Observations Conducted</u>: o Medication Room Observations conducted in the following units: Shamrock, Whiterock, Longhorn, Barrett, and Martin o Medication Administration Observations on the following Individuals: • Individual #300, Individual #595, Individual #873, Individual #568, Individual #414, Individual #284, Individual #972, Individual #305 Individual #21, Individual #235, Individual #65 Individual #90, Individual #10, Individual #639, Individual #325, Individual #236, Individual #192, Individual #227, Individual #550, Individual #539, Individual #528, Individual #231, Individual #300 o Enteral Administration of Formula/ Water Flushes of Individual #197 o Enteral Administration of Medications of individuals: Individual #511, Individual #84, Individual #53 Individual #314 o Residential areas at various times of the day o Nutritional Services Department, 6/4/13

	Facility Self-Assessment: The facility submitted its self-assessment for section M, updated 5/14/13, and provided comments/status for Section M, Provisions M1 through M6 of the Settlement Agreement. The facility rated itself as being in noncompliance with all provisions of section M except M6. The monitoring team agreed that M1, M2, M3, M4 and M5 were in noncompliance and the facility had maintained substantial compliance in M6. The format for both facility self-assessment and action plan continued to provide valuable information for the activities associated with each provision. The action plan, updated 5/14/13, provided the monitoring team with a status of the action steps taken for each provision, included those steps that were completed and/or were ongoing and the projected data of completion. During the monitoring team's meeting with CNE and other members of the leadership team which included the specialty nurses, a detailed review of both the section M and the action plan were provided. During the meeting, it was evident to the monitoring team that the nursing members present were enthusiastic and highly motivated, and had taken ownership toward compliance for each of the provisions presented. This was evidenced by their familiarization with the data contained within the report and the conclusions/analysis associated with the provisions. The team through their interactions with the monitoring team further demonstrated their expectations to provide care that met accepted standards of practices related to assessing, planning, intervention, evaluation, and ensuring appropriate care was provided to meet the health needs of the individuals.
	Summary of Monitor's Assessment: The facility made progress in all provisions. Notably, positive improvements were made in the Provisions M.1, M.2, M.3, M.4., and M6. Provision M.1: This provision was found in noncompliance. The monitoring team noted some improvement in the recruitment and retention of nursing staff. The Nursing Leadership remained stable. The CNE and Nursing Leadership during the monitoring team onsite visit demonstrated collaboration among themselves and strong analytic skills in the identification of issues and promptly addressed problematic issues. Since the last review, the Nursing Operations Officer (NOO) was filled from within and the position vacated, nursing management position was also filled. RN Case Management was fully staffed with 28 RN case managers. The facility was heavily reliant upon agency nurses for staffing. The facility reported, at the time of the onsite visit, 15 LVN vacancies. The CNE reported the Nursing Leadership team evaluated the continued need for Wound/Skin position versus the need for an additional case management position. The Wound/Skin position was converted to a Case Management position, to include the responsibilities of that position. MSSLC Nursing Guidelines for Prevention and Treatment of Altered Skin Integrity were put in place to coincide with the shifting of responsibilities to ensure continuity of care and services. The Hospital/Liaison was relieved of other duties, and was solely responsible for hospital

	admissions and discharge visits and tracking of all hospital admissions and discharges. The Infection Control Program continued to make improvement in surveillance activities of tracking and trending infections, and the implementation of training as conveyed in the report. The requirements for this provision include some overlapping components found in provisions M.2 and M.3 which include the nursing assessments and development of care plans. Other requirements for Provision M.1., include infection control, emergency response systems, availability of relevant medical records, assessment and documentation of acute changes in health care status, quality enhancement, and staffing. The facility must meet all of these components in order be found in substantial compliance. Information addressing assessment and documentation of restraint use is included in section C and death review information is reported in section L of the report. Provision M.2: This provision was found in noncompliance. Although some progress, there remained a need for continued improvement. The RN Case Manager Supervisor was very energetic and displayed strong organizational skills in the assurance of having a consistent method for implementation of quality nursing assessments, health care plans, and promotion of a formalized structured case management system. Much work, however, was needed here. Some of the improvements had been the establishment of a centralized person within case management to provide one-on-one training, mentoring, and shoulder to shoulder interface. Provision M.3: This provision was found in noncompliance. The RN case manager was dedicated to the promotion and development of unified standardized processes in the gathering of accurate data in the completion of nursing assessments. Improvement included the development of prompts within the nursing assessment tool and support of the nursing case managers with one-on-one review competency review of completed nursing assessments. Recently, as of 6/1/13, the state had made a revision to the nursing assessments, thus, with the new change, the facility had not had enough time to assess and evaluate progress. Provision M.4. This provision was found in noncompliance. The Nurse Educator maintained extensive tracking information and systems. The recent filling of the assistant nurse educator position should alleviate the lack of completion of the RN assessment training, as reported in the M self-assessment. For this provision to have substantial compliance, there must be demonstration of an understanding of the policies, procedures, and training, evidenced in the documentation of clinical practices. Provision M.5. This provision was found in noncompliance. In order to obtain substantial compliance for this provision, a process to accurately identify risk and to develop an integrated health care plan, by the relevant disciplines, are required. The newly implemented Integrated Risk Rating Form and Integrated Health Care Plan, and their associated processes were too implemented too recently to demonstrate substantial compliance. Provision M.6. This provision maintained substantial compliance. The monitoring team reviewed the document submission, medication administration pass forms and reports, nine months of medication

	variance data, audits, corrective action plans, and meeting minutes; interviewed nurses and nursing leadership; and conducted onsite observations of medication practices. As evident by these documents and by observations, the facility continued to be in substantial compliance.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The facility section M self-assessment stated noncompliance with this provision and the monitoring team concurred. The monitoring team reviewed the section M self-assessment and section M presentation book, conducted interviews, and reviewed documents. This provision addresses the areas of staffing, medical records, infection control, emergency response, and quality enhancement efforts. <u>Staffing, Structure, and Supervision</u> At the time of the monitoring review, 334 individuals lived at MSSLC. Nursing Department data of the number of LVNs working per shift per day over the past six months was a more useful report because it now included the 10-6 shift, as suggested in the last monitoring report. The reports indicated that the minimum staffing for LVNs were met with the exception of one 6-2 shift, occurring on 10/26/12. At the time of this review, the facility reported the following staff vacancies: One RN II and 15 LVN vacancies. The facility continued to require the use agency nurses in order sustain the minimum staffing levels of LVNs due to the high turnover rates of LVNs, reportedly attributed to poor performance, job satisfaction, and pay. Nursing Administration had taken constructive action to address pay and performance, through a submission to administration for approval for converting LVN IIs to LVN IIIs. Nursing Administration had two significant promotions, in the filling of the Nursing Operation Officer position in February 2013 (vacant since November 2012), and the position vacated by that promotion, the Nurse Manager position. The NOO was a recent Nurse Manager and had seamlessly transitioned to the NOO position. RN Case Management experienced a loss of five RN Case Managers from November 2012 through April 2013, but now reported a full complement of staff. In March 2013, a Nurse Educator assistant was hired, after several months of being vacant. The last monitoring report recommended the Hospital/Liaison be relieved of other additional demands. The CNE instituted a change where the Hospital/Liaison Nurse was now solely dedicated to the role and functions of Hospital/Liaison. To their credit, the CNE and nursing leadership reported on efforts to promote recruitment and retention activities, which have resulted in public radio announcements, and establishing an LVN work group to promote job satisfaction and improved morale. Outcomes from the workgroup resulted in LVNs having the scheduling opportunity for an	Noncompliance

#	Provision	Assessment of Status	Compliance
		every other weekend rotation, rather than one weekend a month. No additional information was available to determine if the very recent new scheduling changes impacted the number of call-ins by nurses. In addition, the CNE reported the Nurse Managers, in the latter part of April 2013, had begun collecting data on nursing functions/activities in order to measure acuity and more effectively evaluate staff assignments. An analysis of the data was not available as reported by the CNE; the information was still in the collection and collating process. The monitoring team will review, at the next compliance visit, the results and actions taken from the analysis of the data for the management of workload based on acuity, that is, to include any correlation with vacancies and call-ins, because these items have direct impact on the provision of nursing in the delivery of care and services to the individuals supported at MSSLC. Additionally, as recommend in the last monitoring report, the CNE and nursing leadership established a plan, completed on 3/1/13, rewarding and recognizing nursing staff positive performance. As this was a very new process, no other information was available as to the success. <u>Availability of Pertinent Medical Records</u> The facility made many improvements toward having an accurate and complete record for each individual as noted below. • Section M self-assessment provided a document entitled Protocol For Diagnosis Entry, dated 3/5/13, a standardized protocol to reconcile diagnosis entries by physicians and psychologists. The process includes participation of nursing, medical, and records departments. • Section M provision action plan, updated 5/14/13, reported that facility was 91.80% compliant in reconciling allergies and sensitivities (also see section N1). • The Nursing Department was currently reviewing individual's current immunization status with required adult immunizations. The data were inconclusive at this time and will be reviewed at the next monitoring visit. <u>Hospitalization and Hospital Liaison Activities</u> Since the last review and based upon a recommendation by the monitoring team, the CNE reviewed the role, functions and assignments, released the Hospital Liaison Nurse from additional demands and responsibilities, and assigned a back-up Hospital Liaison Nurse. From the period 4/11/13 through 4/23/13, eight of the most recent hospitalizations (Individual #38, Individual #165, Individual #216, Individual #314, Individual #535, Individual #881, Individual #446, Individual #994) were reviewed by the monitoring	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>team, the findings were as follows:
• Six of the eight (75%) contained a complete set of pre-post Hospital Plan Checklists, Integrated Progress Notes, and Hospital Liaison Report. Two contained only pre-post Hospital Plan Check List.
• Six of the six (100%) Hospital Liaison Forms were completed contained an associated Integrated Progress Note documented in the SOAP format.

The Hospital Liaison Nurse reported that hospital contacts were a combination of face-to-face or by telephone. Face-to-face visits include observations of the hospitalized individual, interaction with the Direct Support Professional supporting the individual in the hospital, and hospital staff. Reportedly, the Hospital Liaison nurse lacked authorization to access or review the individual records at the hospital and must rely on second hand information from the hospital nursing staff. Often, the receipt of information was hampered by the inaccessibility of hospital nursing staff to requested reviews of the record by the Hospital Liaison nurse. Pertinent information was delayed due to back and forth phone messages for return calls from the hospital nursing staff. Establishing a case management credentialing with the hospital through a memorandum of understanding might be a beneficial mechanism for the accessibility to review onsite records of the individuals. This process could further promote continuity of care between the hospital and the facility. The hospital liaison reports, as they existed currently, were not explicit concerning admission diagnosis, history and physical findings, and treatment plans. This was critical information for the team to have to plan, or to intervene in the individual's care. Of note, hard copies of hospital records were requested and were received, but at much later date.

In addition to the hospital liaison activities the Hospital Liaison nurse conducted monitoring tools for Urgent Care/ER. The findings were as follows:

<table>
<tr><td>Monitoring Tool</td><td>September</td><td>October</td><td>November</td><td>December</td><td>Overall</td></tr>
<tr><td>Urgent/ER Care</td><td>88%</td><td>86%</td><td>95%</td><td>97%</td><td>92%</td></tr>
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<u>Wound and Skin Integrity</u>
Since the last review, the CNE and Nursing leadership restructured the Wound/Skin Integrity platform. These changes included:
• Revised MSSLC Guidelines for Prevention and Treatment of Altered Skin Integrity, dated 5/1/13, to include required committee members and responsibilities of RN Case Manager.
• Revised the following reports: Wound Care Tracking, Weekly Skin report, Wound data collection sheet.</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		• Converted the RN Wound/Skin position to RN Case Manager. • Assigned wound/skin health care continuity and coordination to the individuals RN Case Manager. • Developed training and provide inservice training on the MSSLC Guidelines for Prevention and Treatment of Altered Skin Integrity. • Revamped the committee's function and required attendees. The monitoring team attended the 6/3/13, Skin Integrity Committee Meeting. The meeting was attended by all relevant disciplines, and chaired by the CNE. The committee process included an agenda, handouts on the most current chronic skin conditions, and exampled hidradentitis suppurativia (a chronic skin condition characterized by pea-sized to marble sized-lumps under the skin; painful and can become infected). Although the monitoring team was pleased to see improvement in how the historical data for the last quarter of 2013 were tracked by node, in a linear graph, there remained an absence of analysis of the data, as exampled January 2013 through April 2013 for Wound/Soft Tissue/ Cellulitis. In addition, there were tracking spreadsheets which included individual name, discovery date, location occurred, cause or contributing factor or reason, Braden date, Braden scale Score, type of wound, initial treatment plan, changes to treatment plan, initial assessment, follow-up by RN, progress and date resolved. The reports were sorted and separated by the following categories: diagnosis, type in each unit, resolved/unresolved. Although there were much data reviewed, the data were not inclusive as to whether the pressure wounds or other wounds were hospital or facility acquired. The report was absent of an analysis evaluating progress or lack of progress toward preventing or reducing the incidence of pressure ulcers or other wounds. Although, the facility revamped the processes, there were problematic issues. The SSLC Nursing Services Policy #010, dated 5/11/11, "a skin assessment using the Braden Scale will be completed as clinically indicated, to ensure risk factors for alterations in skin integrity are promptly identified and addressed." The facility reported data for five staged II decubiti occurring between 1/8/13 and 3/8/13, of which two remained unresolved. Upon further review of the five cases: • For four of the reported decubiti, the most current Braden scale dates were for 9/13/12, 11/7/12, 11/12/12, 12/26/12, for the reporting period. • One reported decubiti was discovered on 1/8/13, but had a Braden Scale dated 1/25/13. The decubiti were reported as new occurrences, and a Braden Scale should have been completed, indicating that the facility did not follow policy.	

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		Infection Control Since the prior review, the Infection Control Nurse continued to make many significant improvements in bringing the infection control and prevention to the front lines through the following improvements: • Monthly infection control meetings to identify modes of transmission of current infections, and their prevention. • Identification of proper nursing procedures, obtaining specimens used for clinical correlation in the diagnosis of infections. • Sixteen months of collection of data, 1/1/12- 3/31/13, using linear graphs, for Pneumonia, Urinary Tract Infections, Wound and Skin Infections, Cellulitis, and MRSA. • Conducting and documenting productive infection control meetings. • Implementation of onsite education and mentoring of infections to staff. • Infection control rounds to include environmental discussion with facility maintenance regarding use of air purification systems in the facility's ductwork. • Presentation of the most current relevant information on emerging infections. For example, West Nile Virus and MRSA developments in generally accepted standards and practices of infection control and prevention. • PPD compliance was reported: Individual 99.2%, employees 99%. To the credit of the Infection Control Nurse, there existed a cooperative relationship with the nursing management team, quality assurance, medical, and other departments. The infection control nurse was instrumental in making changes as suggested by entities providing direct aspects of enhancing infection control practices, including, for example, the storage of Personal Protective Equipment (PPE), transmission base precautions, staff responsibility, and providing hands-on training to nursing staff, and Direct Support Professionals. Although there were many positive actions taken, the monitoring team was concerned about the high incidence of cellulitis and urinary tract infections (UTI). Of those infections, by far the largest cellulitis occurred in the Martin Unit, 17 (63%), and urinary tract infections, three (100%). The facility reported:	

	January 2013	February 2013	March 2013	April 2013
Cellulitis	9	6	7	5
Urinary Tract Infections (UTI)	5	7	3	3

#	Provision	Assessment of Status	Compliance
		In addition, Quality Assurance nursing presented communication documentation dated 1/28/13 to the Nursing and Infection control regarding five "confirmed MRSA" cases on Martin. In response to the QA findings, the Infection Control Committee met and discerned a need for a communication system for all staff to be able to identify individuals who required MRSA protocol and the duration the protocol should be in place. Reportedly, a more in-depth meeting followed the Infection Control Meeting with the attendance of the medical director, infection control nurse, Martin nurse manager, and quality assurance nurse. Many recommendations were made. At the next compliance visit, the monitoring team will review these new processes and how they are monitored. As there were a number of recommendations, the facility had not had enough time to evaluate if these processes had made any impact. Even though there was evidence of Infection Control surveillance identifying organisms, documenting treatment, and providing education, there was a need for of a more in-depth analysis of underlying factors that contributed to the continued incidence of these infections. <u>Emergency Response</u> Since the monitoring team's last review, MSSLC self-assessment, committee meetings and interviews with nursing leadership, the following improvements had occurred. • Emergency drills were conducted routinely with no advanced notification. • Revision of the Emergent Event Tracking Form to reflect CPR Event Tracking From. • Increased participation in mock drills by nursing, physicians, habilitation therapists, and psychologists. • Approval and discussion by the committee to further enhance drills and response to emergencies with training and training tools; exampled by the need for abdominal thrust vests to train staff performing abdominal thrusts during a choking incident. • Implementation of the use of two-way radios for timely communication and response to emergencies, and battery powered suction machines, in response to power failures during an emergency. • Assessed, re-evaluated and replacement Automatic Defibrillators (AED) with new ones. • Placement notification of signs where Automatic Defibrillators were located. • Information from previous drills was included as part of the documentation reviewed at the Emergency Response Meeting. Although the facility implemented some improvements addressing the Emergency Response System, the monitoring team, during observations conducted of the emergency	

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		equipment and review of the Mock and Actual Emergency Medical ER Response Meeting Summary dated 1/18/13, found components of the emergency response system to be problematic and requiring action. For the onsite review of medical emergency equipment, five areas were randomly chosen for review by the monitoring team. This included the van used to respond to medical emergencies. The CNE, NOO, Compliance Nurse, and Campus RN were in attendance at the time of the inspection on 6/3/13. The monitoring team found the following: • Defective regulator located in the van, bottle of hydrogen peroxide. Of note, the daily emergency equipment check for 6/3/13 had not been completed, but was considered not delinquent. The monitoring team discussed with the CNE, NOO, Compliance RN, and the attending Campus RN, concern of the heat in the van with oxygen as a combustible agent, along with a bottle of hydrogen peroxide, which, when held, was "hot" to the touch. The attending Campus RN reported that the hydrogen peroxide was not used for treatment and care of individuals. During the inspection, in the back of the van, a breathing mask and oxygen tank contained in a green box was found and immediately removed by the attending nurses. Reportedly, the rear of the van was not used by nursing, and until inspected, the found oxygen tank was an unknown item. To the credit of the Compliance Nurse, a written plan of correction was submitted, reviewed, and implemented. The monitoring team recommended the facility investigate and implement changes in those areas where emergency equipment and or supplies were located. For example, glucometer supplies, oxygen, and drugs may likely have been exposed (or could be exposed) to unacceptable high and low temperature ranges. Of further note, the van had a number of bags with different items maintained in different bags, that is, the van equipment and supplies lack organization, and seemed to be a collection for duplicate items, questioning the efficiency in responding a medical emergency should occur. • Shamrock S-2 was found out of compliance with daily equipment checks, specifically the oxygen. The NOO was present during the finding and immediately put in place a plan of action, and also submitted a written plan of correction. • The monitoring team review of the Confidential Meeting Summary – Medical/Emergency Response Advisory Committee Meeting dated 4/30/13 reported findings of multiple failures with equipment during actual emergency. Examples included failure of an AED to administer a shock, lack of retrievable data from the AED, and electrical outlet failure. Reportedly, the malfunctions occurring with AED were sent back to the manufacturer in order to locate and identify the failure. Reportedly, a contributing factor was the removal of the AED pads after use. Following the onsite review, the facility reported that the AED,	

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after evaluation by the manufacturer, was working properly. The emergency response committee action steps in response to the AED pads were to provide a prompt on the AED machine reminding the operator not to remove the pads. The monitoring team also recommends the facility have an action plan that validates and clearly marks electrical outlets that are operational, non-operational, and those identified as emergency power backup. The monitoring team at the next compliance visit will review all new correctional operational steps put in place for the identification and operation of medical equipment during both mock and real emergencies.
• Meeting minutes of 3/25/13 indicated the CNE was evaluating what processes will be put in place for emergency preparedness, should dual emergencies occur. This included having a second vehicle available for nursing. The monitoring team strongly recommends the committee have a sooner than later action plan to resolve this issue. Following the onsite visit, the facility reported that two vehicles were routinely available as well as a description of some of the back-up planning that was in place. It was surprising that this would have come up as a topic as recently as March 2013 if these procedures and supports were in place.

<u>Quality Enhancement Efforts</u>
The monitoring team was impressed by the Program Compliance Nurse who had prepared a comprehensive summary of the activities since the last compliance visit. The monitoring team was accompanied by the Compliance Nurse and found her knowledgeable of all facets of section M and able to respond to questions and provide supporting documentation when requested. A copy of the Monitoring Sample Sizes and Responsible Persons was provided, outlining the 12 tools to be monitored monthly (Administration Observation Passes, was designated as a quarterly assignment). The monitoring team would like to reiterate the commendable approach taken by the CNE and Nursing Leadership to continue empower ownership in the process, by having Nurse Managers, who are at the front lines and have direct opportunities to provide coaching and performance reviews, participate in the completion of the monitoring tools. Pain Management, Documentation of Seizure Activity, and Documentation of Post Treatment Sedation Monitoring Tools were completed by the Compliance Nurse.

The following is a table of data the entitled Facility's Self-Assessment Section M Monitoring Data submitted for the period of September – February, 2013.
<table>
<tr><th>Monitoring Tools</th><th>September</th><th>October</th><th>November</th><th>December</th><th>Overall</th></tr>
<tr><td>Skin Integrity</td><td>87%</td><td>78%</td><td>80%</td><td>93%</td><td>85%</td></tr>
<tr><td>Urgent Care/ER</td><td>88%</td><td>86%</td><td>95%</td><td>97%</td><td>92%</td></tr>
<tr><td>Nursing Care</td><td></td><td></td><td></td><td></td><td></td></tr>
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#	Provision	Assessment of Status	Compliance

Acute Ill./Injury	78%	80%	93%	78%	82%
Protocol Card Use	74%	81%	81%	89%	81%
Nursing Care Documentation	87%	96%	81%	89%	88%
Infection Control	82%	96%	98%	100%	94%
Nursing Care Resp. Distress	84%	85%	92%	98%	90%
Nursing Care Pain Mngmt.	73%	65%	89%	91%	80%
Nursing Care Prevention	94%	96%	96%	96%	96%
Nursing Care Seizures	88%	87%	92%	81%	87%

Corrective Action Plans (CAP) were implemented and were ongoing for nursing acute care acute illness and injury, nursing protocols, and pain management. The Compliance Program Nurse conducted random verification for section M monitoring completed as follows:

2012	October	November	December
Total # of Corrective Actions Required	67	63	76
Total # of Corrective Actions Completed	62	55	74
Total # of Corrective Actions Verified	52	36	55
% Completed	93%	87%	97%
% Verified	84%	57%	72%

Notably, the monitoring team was pleased to see that the Compliance Nurse, in collaboration and agreement with the QA Nurses, followed the suggestion to re-visit and change how the monitoring tools were graded, that is, each a, b, c of an indicator was now scored separately, rather than counting as a single indicator. One should expect at the next review, that the total number of corrective actions will be higher, due to the change in grading.

The Quality Assurance nurses undertook two self-assessment quality assurance initiatives: problems with feeding tubes to include problems with frequency of tube, and

#	Provision	Assessment of Status	Compliance
		changes, overage, and shortage of enteral feedings. The first initiative was related to an internal assessment conducted by quality assurance after reviewing enteral feeding tube replacement occurrences dated 3/11/13: • One individual was noted to have had 15 enteral feeding tube changes occurring from 9/14/12 through 2/28/13 that required the individual to be sent for replacement - with a reported frequency of change occurring every 11 days. This required the individual to be transported to medical facility for re-insertion each time. Identified contributing factors were documented as tubes clogged with pills, clogging after a new bag of formula was hung, "J-tube came out while patient was being pulled," and documentation of G-tube placement by auscultation. The QA Nurses assessed both retrospective and current data to comprise a facility wide review and established trend categories for reasons for enteral tube changes. Since 9/12/12, the highest reason were for the category dislodged. Since then, there was a significant improvement in two of the categories: dislodged and dislodged during repositioning, turning, check and change. In April and May 2013, there were zero in both categories, resulting in 100% improvement for two consecutive months. • The second initiative was regarding individuals receiving their prescribed formula amounts, and barriers to ensuring individuals are receiving the correct amount of feedings/caloric intake. The data submitted included a review of blanks on the MAR, overage and shortage with perimeters, notification to the PCP, and reviews by an RN. The total number for the categories was on an upward swing, as one would expect as the reporting/data collection process was new. These findings were shared with CNE and nursing leadership who collectively implemented, on 10/15/12, a corrective action plan, ongoing, for both the enteral feeding tubes, and enteral nutrition which included: • Monthly meetings to review, discuss, and implement plans of correction based on feedback from data associated with enteral feeding tubes, and enteral feedings. • Revision of the Enteral Feeding Record, to prompt times, off minutes, and include a key as to why the feeding was off. • Collaborative meetings with CNE, nursing leadership, medical nurse manager, and quality assurance nurses, to implement weekly quality assurance checks, and to provide coaching and performance when a problem was identified. • Nutritionist reviews. • Physician involvement. • Procurement of state of the art enteral feeding pumps that can provide dual delivery of water and formula, and less risk for the individual in developing a	

#	Provision	Assessment of Status	Compliance
		device associated infection. This also required a new type of tube that can be used with the new pumps, of which the facility will track, to distinguish if the new pumps and tubes decrease the number of tube changes. The monitoring team commends the MSSLC facility for taking a lead with an interdisciplinary approach in the self-improvement activities and special recognition to the quality assurance nurses for problem identification, and encourages facility to continue to track, trend, and analyze relevant data on enteral tubes and enteral feedings. These activities have a direct causal relationship to the delivery of quality care and services of supporting individuals with special nutritional needs. The monitoring team encourages the team to research opportunities for subject matter experts, certified or experienced in the management of enteral stomas, tubes, and feeding problems. For example, the provider company vendor may have enteral stoma subject matter registered nurse experts who may be able to assist as part of the vendor training package or as a regular part of general technical assistance. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> The CNE and Nursing Leadership had several processes, both new and ongoing, to sustain and improve communication processes associated with care and services related to individuals' acute changes in health status. • Weekly Focus meetings held by Nurse Managers with unit nursing staff to ensure consistent nursing practices provides opportunity for feedback. Focus topics were tracked by the Compliance Nurse to ensure resolution of problematic issues. The Unit Nursing implemented impressive processes of assessment, communication and documentation for 180 day orders, laboratory orders, and consults/referrals/follow-ups that included quality checks at different levels to ensure the individual plan of care was followed.	
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.	The facility section M self-assessment stated noncompliance with this provision and the monitoring team concurred. The monitoring team reviewed the section M self-assessment and section M presentation book, conducted interviews, and reviewed documents. During the PET IV meeting attended on 6/5/13, the RN Case Manager reported the focus had been on the timeliness of the Nursing assessments, and next steps were focusing on the quality of the nursing assessments. The monitoring team interviewed the RN Case Manager Supervisor on 6/6/13 and found the her to be very organized, with lots of energy toward having a unified case	Noncompliance

#	Provision	Assessment of Status	Compliance
		management system. This was evident by the work products shared, the Nursing Assessment, which contained prompts and guidance for completing, and "Quick Tips" a guide for RN Case Managers. The RN Case Manager Supervisor had assigned an RN Case Manager as the mentor who reviewed, trained, and critiqued the nursing assessments, ensuring uniformity and consistency of an accurate analysis of the individual's health status. The RN Case Manager had re-distributed RN Case Mangers by unit: Longhorn – four, Barrette - four, Shamrock - five, Whiterock - seven, Martin – eight; for a total of 28 RN Case Managers. Additional activities conducted by the RN Case Manager Supervisor were as follows: • Developed Quick Tips which are included in the RN Case Managers Handbook. • Hired four new RN Case Managers. • Re-distributed Case Load Assignments. • Held focus meetings with Nurse Case Manages for performance expectations regarding nurse assessment summaries and content of the revised Wound Care guidelines. • Identified problematic performance issues and instituted corrective action. • Developed a Comprehensive Nurse Assessment content guide, clarifying the expectations. • Received additional RN Case Management duties, responsibility for wound care issues from onset to resolution, including wound tracking, and collaborate with the habilitation department when a wound related to positioning, a non-healing wound, a Braden Score less than 12 occurs, and/or a complicated wound occurred. • Communicated a process change for the review of seizure records, such that the RN Case Manager no longer had to review every seizure, and instead was to only review "if you notice a trend or increase in number," however, following the onsite review, the facility provided additional information stating that the RN Case Manager was responsible to review and sign each week, the seizure records. The monitoring team was concerned that part of the process should include review with whoever witnessed or discovered the seizure for pertinent information that may not have been previously recorded. An increase in seizure by even just one occurrence could be significant for some individuals, even though there might not be a "trend." This is a critical issue, as nurses new to the field of developmental nursing may lack experience in seizures with this population. • Tracks Annual assessment delinquencies.	

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		In addition, the RN Case Manager conducted monitoring tools for Nursing Care Annual Assessments, Nursing Care Plans as follows: Monitoring Tools: Nursing Care Annual NCPs — September: 95%; October: 90%; November: 91%; December: 94%; Overall: 93% Five of the most recent nursing discharge summaries for individuals who transitioned to the community, (Individual #252, Individual #340, Individual #196, Individual #434, and Individual #411) are described below: • Four of the five (80%) had documented a review of the Health Care Plan. • Three of the five (60%) included the most recent quarterly lab and lab values. • Two of the five (40%) documented, under the header "other pertinent information, i.e., special behaviors and what they mean, how I communicate, signs and symptoms of pain etc." For one, the nurse wrote "Nothing special. Individual #411 likes to talk." For the other, the nurse wrote "He is capable of voicing his needs". • Four of the five (80%) noted that attachments were needed for the current medication list, current immunization record, last Moses/Discus, Integrated Risk Rating Tool and Action Plans, and Nursing Care Plans/Staff Instruction Sheets. • Zero of the five (0%) adequately described how the individual participated in his or her own care, or explained his or her progress toward desired health. The Nursing Discharge Summaries are powerful documents that can be used support the individual in the next setting (i.e., the community). The Nursing Discharge Summary should be a more meaningful document that could be used by any team member to support the individual after discharge. Section M.1 of the facility's action plan indicated an inservice training on the revision of NS 48 Nursing Discharge Summary Form on 5/1/13 and projected for completion on 6/15/13. The monitoring team did not find written guidelines for discharge planning. The monitoring team will review Nursing Discharge Summaries at the next compliance meeting. Much work is needed here. The monitoring team selected sample of records to review for the Admission, Annual, and/or Quarterly Comprehensive Nursing assessments completed over the last three months including the current month for Individual #35, Individual #597, Individual #285, Individual #414, Individual #188, Individual #80, Individual #237, Individual #115, Individual #314, Individual #518, and Individual #521 . • Four the six (67%) of the Annual Assessments were completed within 10 days of the annual ISP meeting. • Four of the four (100%) Quarterly Nursing assessments were completed in	

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		accordance with the ISP schedule. • One of one (100%) of the Admission Nursing assessments were completed within 30 days of admission as required. • 11 of 11 (100%) contained the RN signature and completion date. • 11 of 11 (100%) contained a completed Braden Scale. Admission, Annual and/or Quarterly Comprehensive Nursing Assessments, Section I through IX, were positive for improvements since the last monitoring visit. Nursing summaries remained problematic, as most were a regurgitation of dates, rather than summary statements. For those individuals who had a diagnosis of a genetic syndrome, the nursing assessments/analysis/summary did not include how the individual's health was impacted or associated risk. Other problematic areas included: • Current Active Medical Diagnosis was not updated when a new diagnosis was added or when a diagnosis was removed. • Change in recent health status related to a specific body system was not in the respective summary. • Bowel management plans were not consistently updated. • Summations of observations of enteral feeding were not addressed in the respective summary. Notably, PRN medication orders were listed under the medication section, and noted in some cases to be six months without a documented need for the PRN medication. Nursing and Medical consideration should be given evaluate the necessity continuum of PRN medications orders. Although some improvements were found, this provision was found in noncompliance. The monitoring team recommends the Nursing Department should continue training, shoulder to shoulder supervision, and one-on-one competency based nursing summaries to ensure that nursing diagnosis/problems are summarized to accurately represent the individual health status.	
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	The facility section M self-assessment stated noncompliance with this provision and the monitoring team concurred. The monitoring team reviewed the section M self-assessment and section M presentation book, conducted interviews, and reviewed documents. To the credit of the CNE, initiated the development of a tracking sheet for weights facility wide. This was adopted by the Nutritional Team who added to the document, thereby, making it more useable and a more robust system for assessing, managing, and tracking nutritional status. The monitoring team was impressed with the nutritional staff's newly	Noncompliance

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	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.	designated space. Notably, one of the systems in place promoted the individuals' independence and participation in nutritional health, such as a walk-in service model for questions, requests, and/or counseling. The monitoring team selected from the 20 record requested for the last three months and current month to review Admission, Annual and Quarterly Comprehensive Assessment and completed Health Care Plans (HMPs). The monitoring team noted positive improvements in the last three months. . • 20 of the 20 (100%) individuals had HMPs for all risk ratings. • 20 of the 20 (100%) of the HMPs included instructions for the Direct Support Professional. • 20 of the 20 (100%) the HCPs instructions were written in terms the Direct Support Professional could understand. The monitoring team reviewed four of the most recently completed and/or active Acute Care Plans for acute illness/injury (for Individual #352, Individual #35, Individual #98, and Individual #460). • Four of the four (100%) contained sufficient information to identify the reason for the acute care plan. • Four of the four (100%) Acute Care Plans were individualized sufficiently to meet the individual's care needs. • Four of the four (100%) Acute Care Plans interventions addressed the acute illness or injury. • Four of the four (100%) Acute Care Plans included care staff instructions that were easily understandable. • Four of the four (100%) Acute Care Plans had documentation that Direct Support Professionals had been trained on the Acute Care Plans. • Two of the four (50%) Acute Care Plans were for infections. • One of the four (25%) Acute Care Plans was for an acute injury. • Four of the four (100%) included a NANDA diagnosis. • Two of the two (100%) had Integrated Progress Notes with documentation that the Antibiotic Protocols were followed. The self-assessment by the facility and monitoring team were in agreement that although there were positive improvements to Nursing Care Plans, health care plans remains problematic in revising treatment and resolving healthcare issues.	

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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.	The facility section M self-assessment stated noncompliance with this provision and the monitoring team concurred. The monitoring team reviewed the section M self-assessment and section M presentation book, conducted interviews, and reviewed documents. On a positive note the continuation of collaboration and ownership continued in the area of nursing education to the credit of the Program Compliance Nurse and Nurse Educator. An excellent example of this was in the area of Nursing Protocol cards where training included the importance of tying in assessment and documentation, thus, enhancing the processes of critical thinking. Since the last compliance visit the Nurse Educator formal Preceptorship Training dated 4/17/13 was in the process of training nurses. The model supported a more individualized orientation program based on trainees' clinical expertise experience and assigned work area. Reportedly, the total number receiving Preceptorship Training to be completed for 9/1/13 was 26. Of those nine (35%) had been completed: four RNs and five LVNs. Nurses who were selected to mentor new nursing hires also received training. Since the last review, the Nursing Annual Competency Skills fair was held, where stations were equipped with appropriate training materials. This was a notable team effort with instructors from the areas of nursing administration, compliance, case management, and education. The annual skills fair took place on 1/8/13 and was completed on 1/10/13. The Skills fair incorporated the use of protocol cards, such as a glucometer station, and a seizure protocol prompt for glucose check. A 92% compliance score was reported for RNs and 99% for LPNs for Skills Competency. Training on SOAP documentation was targeted for completion by 9/1/13, for a total of 120 nurses completed, and 62 (51%) to be completed. Physical Assessment training for RNs revealed 77% had completed training. The Nurse educators had continued to train nursing staff, utilizing the Nurse Education Handbook. The nurse educators tracked and reported, through an extensive spreadsheet, nursing training completed by each nurse, specific to name, title, and course name. Training/Inservice activities since the last review by the monitoring team included: • Training Integrated Health Care Planning to Interdisciplinary Team members, 11/5/12 • Annual Competency for Neurological Assessment, 1/8/13 • Inservice on the Glasgow Coma Scale additions to the Neurological Record and Protocol, 4/-1/13. • Inservice on the review of allergies prior to initiating an initial does of medication10/30/12.	Noncompliance

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		• Training Acute Care Plan and Development, 12/14/12 • Annual Skills Fair 1/8/13 • Annual Moses and Discus Training, 3/21/13. • Medication Positioning Training, 3/27/13. • Self-Administration of Medication Training, 5/15/13. • Mosby's Physical Assessment Class, 5/14/13. • Moses and Discus Avatar Training, 3/27/13. • Preceptor Training Role, novice to Expert, Assignment Management, 4/17/13. • Physical Assessment Training, 10/22/12. • Integrated Risk Rating Form and Integrated Health Care Planning, 11/5/12. • Inserviced Staff on revision of NS 48 Nursing Discharge Summary, 5/1/13. The Nursing Department should continue its much improved expanded efforts of collaboration and ownership both internally and externally because this further promotes integrated assessments and health care practices across the facility, ensuring they are sufficiently addressing health care needs of the individuals residing at MSSLC. Although there were notable improvements in M4, as exampled by the many integrated education activities, the monitoring team was in agreement with the facility's self-assessment that M4 rating was noncompliance, as Nursing Policies, procedures, processes, and protocols had not sufficiently been put in place to meet the individual's needs.	
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.	The facility section M self-assessment stated noncompliance with this provision and the monitoring team concurred. The monitoring team reviewed the section M self-assessment and section M presentation book, conducted interviews, and reviewed documents. The CNE and Nursing Leadership, in response to the monitoring team recommendations worked to improve the collaboration and cooperation between the Nursing and Habilitation Departments in order to improve the coordination of health care. Examples included contributing to the hiring of a new habilitation director, and the PNMT nurse attending nursing administration meetings to build on a working relationship and address concerns of the PMNT. The monitoring team will follow-up at the next visit to evaluate the effectiveness of these processes related to continuity of care delivery of care and services by the partnership between Nursing and habilitation. Since the last compliance report, new processes were put in place for the Individual Support Plan (ISP), Integrated Risk Rating From (IRRF), and Integrated Health Care Plan (IHCP). It was impressive to note the facility had conducted reviews of random samples	Noncompliance

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		of IRRFs for content and timelines. The facility self-assessment reported a review of all ISPs which included the IRRF/IHCP were attended 100% by RN Case Managers. The monitoring team reviewed the revised At Risk Individual Policy and associated ISP, IRRF, and IHCP processes. Nursing Leadership had chosen to use terminology that can be easily understood by individuals who participate in their own care plan and for those staff providing the day-to-day direct care. The monitoring team reviewed, from the sample of 20 records requested by the monitoring team, individuals for the last three months and current month and reviewed six of the most recently completed Integrated Risk Rating Forms and Individual Integrated Health Care Plans (Individual #521, Individual #597, Individual #285, Individual #98, Individual #80, Individual #35). • None of six (0%) had any reference as to how the individual would participate in the health care plan; most statements included the individual would be encouraged, or he/she would likely attend. • None of six (0%) were written in person centered language. • None of six (0%) indicated how the individual participated in the health care goals. • One of six (16%) reported in the Nursing Assessment the individual participated in the self-administered (SAMS) program. The individual refused to document the self-administration. The Annual IHC indicated the nurse administered medication. Seven Aspiration Trigger Data Sheets and Integrated Progress Notes were identified from the 20 requested records by the monitoring team. The following individuals were selected as having medium or high risk for aspiration: Individual #188, Individual #296, Individual #285, Individual #314, Individual #80, Individual #35, and Individual #518. The monitoring team found the following: • Zero of seven (0%) had individual aspiration triggers identified. • Zero of seven (0%) were filled out daily, on each shift • Seven of seven (100%) were reviewed and initialed on a weekly cycle by the case manager • One of six (16%) had triggers marked on the 6-2 pm shift for the month of April 2013 for Individual #314 which was documented with coughing with signs of struggle, watery eyes, drooling, facial redness, wet vocal quality/quality, spit on front after or during eating, formula on mouth on in mouth/nose and vomiting. To the credit of the Direct Support Professional, as recorded by the nurse, the DSP provided a detailed description of the episode of vomiting, color, and amount to the nurse. The color of the emesis was brown. The IPN recorded at	

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		10:15 am provided pertinent information that at the time of the conducted assessment 9:00 a.m., noting that earlier in the day the J-of the GJ combination tube had become clogged, and staff were unable to unclog the J-tube. The G-tube was connected to a Foley drainage bag of which the drainage was described as brown and greater than 100 cc. The nurse completed a physical assessment which included a full set of vital signs. Findings were positive for the individual having abdominal discomfort when palpated during the abdominal assessment. The nurse contacted the Physician Assistant, provided the assessment findings, and advocated through a discussion to the PA, that the individual go to the Emergency Room "to get re-hydration and H and H redrawn, and get PRN suppository due to her vomiting this am and going on the ambulance ride instead of going to interventional radiology." Orders from the PA to administer the Phenergan suppository and to contact the medical director, of which a phone message was left. Later, the PA later informed the nurse that he had talked with the medical director noting awareness and that the individual had some brown emesis early in the morning. Orders by the PA were for the individual to be sent to intervention radiology in the am, labs were ordered to be rechecked at the facility in the morning. The record documentation next entry was at 5:10 pm by the RN, who documented what the LVN had reported: the individual had vomited, the Pedialyte the individual had been receiving was stopped, and there was brown emesis (vomit) to towel. The "sick call" nurse was called who reported the information to the PA. Orders received from the RN from the PA were to give the Phenergan suppository and follow the Vomiting Protocol. The vomiting protocol, however, was not followed for the 5:10 pm episode. The monitoring team had concerns that the PA ordered the nursing staff to continue to administer PRN medication without thoroughly exploring the continued underlying cause of the vomiting. • One of six (16%) had triggers marked for vomiting in May 2013 on the 6-2 pm shift (Individual #188). The vomiting was reported by the respiratory therapist (RT) at 3:00 pm, who completed a through respiratory assessment, and documentation of notification to the nurse. The RT note was absent of the time of notification to the nurse. The next entries on the IPN were recorded by nursing at 6:00 pm. The documentation from both of these entries were absent in assessment of the vomiting, as to amount, color, and frequency and whether or not aspiration precautions, such as positioning, were in place during the reported episode. The nursing protocol for vomiting was not followed. The facility reported timeliness for completion of the IRRF 10 days prior to due date for completion times as follows January 95%, February 82%, and March 52%. The monitoring team suggests the Nursing Department assess the factors for the downward trend in March 2013 and take appropriate action for improvement.	

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M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility section M self-assessment stated maintenance of substantial compliance with this provision and the monitoring team concurred. The monitoring team reviewed the section M self-assessment and section M presentation book, conducted interviews, and reviewed documents. Overall, there was continued progress in the maintenance and growth of existing systems in place to assess, plan, and evaluate all the components of medication safety. These included monitoring, tracking and trending, data analysis, and identifying and problem solving though a unified interdisciplinary team. This approach included health care professionals and other ancillary team members. Since the last review, the CNE and Nursing Leadership identified and addressed communication issues between the pharmacy and nursing staff with regard to medication delivery by use of two-way radio. Reportedly, this process allowed for quicker response time between the entities for problematic issues associated with medications, such as wrong medication delivered. The nursing team and pharmacy teamed up to reduce medication variances, such as pills were now split before packing by the pharmacy, and double signatures were required on orders. <u>Administration</u> The monitoring team conducted 28 medication pass observations and interviewed seven nurses in each of the units during various times of the day and evening during four different days during the week of the onsite review. These observations included oral, crushed medications, medications via tube, medications given with different mediums (e.g., pudding, thickened liquids). The observations additionally included individuals who self-administered or were participating in a self-administration training program. The monitoring team was accompanied by a member of the leadership team on all observed medication passes. Each of the nurses administered consistently practice good hand hygiene and glove exchange. Carts were observed as clean and uncluttered. Security of the carts was maintained at all times. Scheduled drugs were observed to be under double lock. All of the medication passes met professionally accepted standards, with the exception of one, occurring on the Martin unit. It was an agency nurse who did not identify the individual prior to administration. The NOO was in attendance and quickly intervened by prompting the agency nurse with the correct standard. During the same observation period, the agency nurse was observed to be unfamiliar with working with tubes, and self-reported to not have had the opportunity to have worked with tubes in four years. The agency nurse also self-reported that she was not familiar with the individuals to whom she was assigned. To the credit of the NOO nurse, she quickly prompted the agency nurse reminding her of the importance and assistance available from the Direct Support Professional who is most familiar with the individual and can	Substantial Compliance

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		assist in the identification and safe placement of the individual's feeding equipment. Reportedly, the agency nurse received the general core orientation and met competency. Surprisingly, the agency nurse during these observations had also been assigned to train/orient a new nurse, who was also present. The NOO nurse immediately removed the nurses from the current assignments and reassigned the agency nurse for remedial training. In addition, a written remedial action plan was submitted by the NOO. The monitoring team spoke with the CNE and Nursing Leadership about the need for them to include a closer review of the knowledge, skills, and abilities of new hires/agency nurses and ensure shoulder to shoulder competency. On a positive note, the NOO described a new process currently in the development stages for all new hires/agency nurses, that is, to be re-interviewed and ascertain the skill level prior to making any assignments. Of note is that, upon a subsequent medication administration observation by the monitoring team, the nurse performed exceedingly well in all aspects of medication administration, and interacted with both the Direct Support Professional and the individual. The nurse was also cognizant of the individual's preferred preference of mediums/and or liquids. Further, the nurse, when getting ready to begin the medication pass, was stopped by one of the Direct Support Professionals to ask for assistance regarding another individual's drainage bag. The nurse immediately put the locked cart back in the medication room, and assisted the Direct Support Professional with her concern. The attention by the nurse was commendable, but raised the issue as to what support was in place by Nursing Leadership to ensure that these nursing functions can be handled promptly while preventing distraction of the administration of medication, which can be a contributing factor to medication variances. <u>Documentation</u> • 28 of 28 (100%) of the observed medication passes had accurately recorded initials in the medication entry box and there was a corresponding signature for each of the initials. • 28 of 28 (100%) had no blanks on the Medication Administration Record for June 2013. <u>Storage</u> Five units were examined by the monitoring team in the areas where medication passes were observed. All medications were properly stored and locked. Controlled drugs were maintained under double lock with records indication medication counts. Refrigerator temperatures were checked daily and all temperatures were recorded on the logs. All medications had clearly marked expiration dates. External and internal medications	

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		were separated from each other in accordance with standards of accepted practice. Oversight and Monitoring The facility continued to meet accepted standards of practice in following the SSLC Medication Administration Guidelines, effective date 2/11, MSSLC Nursing Medication Variances #25, Implementation date 11/3/11, and SSLC Enteral Medication Administration effective date May 2011. The facility continued to monitor and track actual and potential medication variances that occurred and reconciled medication shortages. The facility self-assessments reported medication observations passes performed in the last six months 100% were completed and successful. The monitoring team attended the Medication Variance Committee (MERC) on 6/11/13. The meeting was chaired and the data were presented by the CNE. There was some confusion within the meeting by the attendees, regarding both how the data were calculated and the interpretation of the data. An example was the May 2013 Medication Pass Observation data. The originator of the data had to be summoned to the meeting to provide interpretation of the data. The process of collecting was still a work in process. The monitoring team recognized the continued interdisciplinary positive progress between disciplines in the areas of collaboration, problem solving, and taking ownership in ways to improve existing systems. Examples of this were the need to clarify orders, sharing of education, and using actual scenarios of cases when there are unique problems occurring with medication variances. Of note, from the Medication Variance Committee minutes and meeting attended, the monitoring team had difficulty in following what specific actions had been taken, the actual dates of implementation, and the effectiveness when addressing problematic issues. The monitoring team recommends the CNE overhaul the presentation and content of the meeting to include specific timelines of actions taken, problems resolved, and what problems continued. During the meeting, several issues were brought forth by the attendees that continued to plague the facility. One of the more serious concerns was the occurrence of transcription errors. To the credit of the pharmacist, a recommendation had been made for nursing to implement a process of having two signatures on the physician orders ensuring the completion of the document (though following the onsite review, the facility reported that this was for MARs; clarification during the next onsite review should occur). The members of the committee were in agreement that this action step could be beneficial in reducing the number of transcription errors. Nursing will need to ensure, given the several steps involved in double checking signatures, that the inservice produces practices that are consistent across the facility. Because the inservice began in May 2013, it was too early to know what impact there would be.	

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		The Medication Variance Committee reported in the 6/6/13 meeting minutes on nine continuous months of data. Data were trended by type of error, shift, node, severity of variance, and variance by department. The trend data in the format of a linear graph was difficult to discriminate which colored line was E+ or A. E+ also was inclusive of the remaining other categories. The trend data for category C revealed a slight upward trend in March 2013, reportedly due to one transcription error resulting in 59 variances. The monitoring team suggested the CNE considered each category have its own distinguishing line of transparency as categories H though I were significant, even with a reporting of low numbers because they represent a variance that could have resulted in temporary harm, prolonged hospitalization, permanent harm, require interventions necessary to sustain life, and/or contributed or resulted in an individual's death. The monitoring team review the Pharmacy and Therapeutics Committee minutes for 12/28/12 and 3/26/13. The Pharmacy and Therapeutics Committee revealed attendance by the CNE, Infection Control Nurse, and Quality Assurance Nurse who provided information of problems identified and actions taken, in the respective areas of Infection Control, Standards of Medication Practices, Medication Variances, and Corrective Action Plans. Refer to Provision N for information regarding the Pharmacy and Therapeutics Committee meetings. The monitoring team reviewed a sample of 12 of the most recent Medication Variance Reports in the document request. Findings included: • Five of 12 (42%) were completely filled out. Four of the Medication Variance Reports did not contain any data to identify why the variance occurred. In two of the Medication Variance Reports, the second page was blank. • Seven of 12 (58%) medication variances were discovered and reported within 24 hours. One medication error was not discovered for 79 days of the individual receiving wrong doses of medication being administered as a result of two identical orders on the Medication Record. The Medication Variance Form completed surmised the nurse may not have distinguished between the generic and brand name of the drug. • Eight of 12 (67%) had appropriate corrective action taken by the supervisor. • Four of 12 (33%) were completely blank for any corrective actions taken. • Ten of 12 (83%) medication variances were graded correctly on the severity index. Two, were not marked as to the severity. Two were noted to be omissions as to the type of variance, but coded as Category B. which is not congruent with the Medication Variance Policy #25 guidance; the result should have been recorded as Category C. • Eight of 12 (67%) medication variances described how the variances occurred.	

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		• Medication variance trends by unit: Martin, six of 12 (50%); Longhorn, four of 12 (33%) CNE and Nursing Leadership should make sure Medication Variances Reports thoroughly addressed all sections of the Medication Variance Form, as the information is reflected in the data entry systems.	

Recommendations:

1. Assess and implement changes in those areas where emergency equipment and or supplies have been exposed or could be exposed to unacceptable high and low temperature ranges in accordance with manufacture guidelines (M1).

2. Develop and implement a back-up plan for coverage of more than one nurse to respond to an emergency (M1).

3. Continue the progress with the infection control program and develop a more in-depth analysis for underlying factors that contributed for the continued incidence of infections (M1).

4. Develop Discharge Guidelines to ensure the information is complete accurate, current, and includes information on how the individual participates in his or her own health care (M2, M3).

5. Continue to provide Nurse Case Managers with training and supervision on training of Nursing Summaries to ensure the individual's overall health care status is represented in the nursing quarterly, annual assessments (M2, M3, M4).

6. Ensure nursing interventions that require or include notification to physicians are recorded with time of day (M1).

7. Ensure follow-up documentation is specific to which Post Hospitalization date is being followed, for those individual experiencing more frequent hospitalizations (M1).

8. Continue the collaboration and ownership both internally and externally with nursing, allied health partners and others in order to sufficiently address health care needs of the individuals residing at MSSLC (M4).

9. Ensure all Medication Variance Forms are filled out completely because data from these forms are used to make medication safety improvements (M6).

10. Overhaul the presentation and content documentation of the Medication Variance meeting to include specific timelines of actions taken, problems resolved and indicate what problems continue to need interventions (M6).

11. Ensure medication variance data for each category is represented (M6).

12. The Quality Assurance nurses, in continued collaboration with CNE and Nursing Leadership, should continue tracking and documentation of overages and shortages enteral feedings, and analyze the underlying contributing problems (M1).

The following are offered as additional suggestions to the facility

- Obtain through a memorandum of understanding, authorization for the hospital nurse to review the individuals' record at the time of the visit, thus promoting continuity of care during the hospital admissions and discharge visits (M1).
- Ensure with monitoring frequency electrical outlets are operational, and that emergency outlets dare clearly marked (M1).
- Support the Nursing Department with availability of more than one emergent transport vehicle, for the possibility of an emergency and or a drill occurring at the same time (M1).

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #011: Pharmacy Services, 9/26/11 o DADS Policy #009.2: Medical Care, 5/15/13 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, 1/10/13 o MSSSLC Policy and Procedure Medical #29, Quarterly Drug Regimen Review, 1/10/13 o MSSSLC Policy and Procedure Medical #30, Adverse Drug Reactions, 1/10/13 o MSSSLC Policy and Procedure Medical #31, Drug Utilization Evaluation, 8/16/12 o MSSLC Policy and Procedure: MOSES and DISCUS o Pharmacy and Therapeutics Committee Meeting Minutes, 2012-2013 o Medication Variance Review Committee Meeting Notes, 2012-2013 o Polypharmacy Committee Meeting Minutes 2013 o Clinical Interventions Log, October 2012 – March 2013 o Review of Physician Orders, October 2012 – March 2013 o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations • Risperidone, Olanzapine, and Carbamazepine o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #754, Individual #519, Individual #170, Individual #671, Individual #198, Individual #441, Individual #109, Individual #554, Individual #64, Individual #538, Individual #178, Individual #449, Individual #127, Individual #157, Individual #591, Individual #177, Individual #407, Individual #577, Individual #493, Individual #538 Individual #600 Individual #587, Individual #314 o MOSES and/or DISCUS Evaluations for the following individuals • Individual #290, Individual #476, Individual #235, Individual #305, Individual #614 Individual #150, Individual #436, Individual #263, Individual #466, Individual #592, Individual #253, Individual #17, Individual #503, Individual #309, Individual #384, Individual #861, Individual #284, Individual #2, Individual #593, Individual #934

	Interviews and Meetings Held: o Anyssa Garza, PharmD, Pharmacy Director o Abigail Okeke, PharmD, Clinical Pharmacist o Christopher Ellis MD, Medical Director o James Gilley MD, Primary Care Physician o Admerle Hoskins, DO, Primary Care Physician o Michael Meyerson, MD, Primary Care Physician o Kendall Brown MD, Staff Psychiatrist o Madhu Rao MD, Staff Psychiatrist o Juanita Kirby, MD, Staff Psychiatrist o Prakash Shett, Staff Psychiatrist o William Thomas, PA o Angela Johnson, RN, Medical Compliance Nurse 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 o PET 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. For Provision N1, the pharmacy director conducted three activities as part of the self-assessment. First, a random sample of physician orders was reviewed to ensure that the pharmacist communicated with medical staff. Second, a random sample from the drug interaction reports was reviewed to determine if proper communication and documentation occurred. The third activity was to review clozapine monitoring. The compliance rates were determined to be 98.7%, 84.7%, and 92.1% for the three items assessed. An overall compliance rating was determined to be 91.9%

	The self-assessment, however, did not include any assessment of the pharmacists' use of the Intelligent Alerts, which is a major component of the provision N1 and is assessed by the monitoring team. Determining compliance scores for each activity provides some idea of how the facility is performing. However, averaging the scores for three different types of activities may be misleading. Poor performance in one area cannot be compensated for by better performance in another area. Thus, averaging the scores is of little value. 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, N3, N4, N6, and N7. For provision items N5 and N8, the monitoring team found the facility to be in substantial compliance with N4 and N7. The facility remained in noncompliance with provision N1, N3, N5, N6, and N8. Provision N2 moved from substantial compliance to noncompliance.
	Summary of Monitor's Assessment: The pharmacy was staffed with a pharmacy director, a clinical pharmacist, two full time registered pharmacists, and four technicians. Since the last compliance review, a clinical pharmacist resigned and the position was temporarily filled by contract pharmacists. There were also changes in the pharmacy technician position. A full time pharmacist was hired in May 2013. Contract pharmacists provided services from December 2012 through May 2013. However, the pharmacy director reported that staffing changes had a significant impact on the operations of the pharmacy. The clinical pharmacist primarily functioned as a dispensing pharmacist and that vacancy resulted in the pharmacy director and the remaining clinical pharmacist filling the void in the pharmacy. The momentum seen in the last compliance review was dampened by these staffing changes. Notwithstanding these setbacks, the pharmacy director remained very steadfast in her efforts to improve medication practices at the facility. Her presence and contributions to the department and the facility were visible throughout the week of the review. It appeared that the pharmacy department worked collaboratively with other clinical areas, such as medical, nursing, and habilitation services. The documentation of communication between the pharmacists and prescribers improved. During the September 2012 monitoring review, it was reported that the Intelligent Alerts module of WORx was implemented in June 2012. However, the facility did not execute the process in accordance with state guidelines largely because the decision was made to override the alerts. The practice of overriding alerts occurred from June 2012 to March 2013. The QDRR process showed a substantial decline with regards to timelines and, to some extent, the quality of the reviews diminished as well. Even with stabilization and full staffing, the timelines for completion did not improve during the month of May 2013. The facility continued to have difficultly completing the MOSES and DISCUS evaluations. Compliance with completion was marginal, substantial delays were noted with prescriber reviews, and many evaluations were not appropriately completed. This was an ongoing

	problem at MSSLC that appeared recalcitrant to numerous corrective actions. The pharmacy department staff provided training on the ADR system as part of new employee orientation. Overall, the number of ADRs reported increased. Nonetheless, there continued to be a disconnect between the ADR system and the greater system of monitoring for psychopharmacologic side effects. The ADR data log often indicated no plan of action for individuals who experienced medication effects that had the ability to diminish quality of life. Drug utilization evaluations were completed as required and provided good information for facility staff. Corrective actions were implemented and the facility will need to monitor the effectiveness of the corrective actions. Finally, the monitoring team saw no progress in the medication variance system. Problems were noted in all five components of the Medication Use System. The monitoring team was particularly concerned about a disturbing increase in "wrong med" dispensing errors, long-term errors, and errors that were repeated due to faulty systems.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the	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. A sample of physician orders was also reviewed. Summary data are presented in the chart below.	Noncompliance

Prospective Reviews 2012 – 2013
Events per Month

	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Clinical Interventions	11	39	39	22	25	27	28	32
Review of Physician Orders	34	16	25	28	25	20	26	39
Types of Clinical Interventions								
Lab Monitoring	21	5	19	13	8	3	25	--
Therapeutic Duplication	14	5	9	8	12	7	14	--
Supratherapeutic Doses	7	10	0	8	0	0	4	--
Avoid ADR	14	12	0	13	12	14	0	--
Avoid DDI	35	40	15	46	68	69	21	--

	prescribed dosage is not consistent with Facility policy or current drug literature.	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. Problems related to lab monitoring and allergies were frequently documented. The pharmacy director described several initiatives that were developed to address these concerns. A corrective action plan was in progress with nursing services to resolve allergy discrepancies and the medical staff was working on distinguishing medication allergies from medication sensitivities. Information obtained from the clinical interventions also resulted in some efforts with habilitation services, such as reconciling PNMPs to ensure that individuals were receiving the correct form/texture of medications. 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 related to incomplete orders, such as missing indications, stop dates, and routes of administration. The medical staff was provided template stamps to help improve physician order writing. Problems related to the size of the stamp limited its use. The pharmacy director reported that the prospective data were submitted to the medical director each month. The minutes of the Medical Review and Pharmacy and Therapeutics Committees indicated these issues were discussed. Finally, this provision item required "upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about… the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication." The facility implemented the Intelligent Alerts, which required laboratory monitoring for eight drugs including carbamazepine, dilantin, valproic acid, phenobarbital, lithium, levothyroxine, warfarin, and potassium. 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. The pharmacy director reported that monitoring for carbamazepine and potassium were added since the last review. Notwithstanding the required implementation, MSSLC did not utilize the Intelligent Alerts as required. Per direction from state office "all justification boxes except 'order written consistent with facility protocol' will have a mandatory explanation box. There, the pharmacist will document the reasoning for not having the order or the conversation with the prescriber regarding the lab order. A report indicating all lab orders/monitoring will be ran weekly or monthly to ensure that monitoring is occurring and the Pharmacy Director or designee will discuss with the Medical Director on a monthly basis, any patterns or prescribing concerns."	

		This process did not occur at MSSLC. The pharmacy department made the decision to override the Intelligent Alerts for nine months following implementation. The pharmacy director noted in a document dated 6/26/13, "the pharmacist would see the alert, but press cancel… which would stop the alert from appearing again." The appropriate use of the justifications was implemented on 3/19/13. Since the IAs were overridden, there were no routine reports generated on a regular basis as recommended by state guidelines. The failure to implement the IA module as directed was unfortunate. Throughout the week of the compliance review, the monitoring team heard anecdotal accounts of the challenges with laboratory monitoring at the facility. The facility's various monitoring tools and activities affirmed these accounts. Lab monitoring was not completed as required and, in some instances, lab monitoring was done when not indicated. Thus, the RN case managers were given greater responsibility in monitoring the completion of labs. Corrective actions related to these problems are discussed in further detail in section N2 and section N7. Given the importance of appropriate lab monitoring, the failure to utilize the IA module was a significant one. While it appeared that progress was made in documenting interventions, the monitoring team is concerned about the continued need to address allergies and the need for lab monitoring. Achieving substantial compliance will require several additional steps including: • The facility should continue to address the problems with more careful data analysis. Averaging unequal types of data to determine compliance rates may diminish the magnitude of the problem and result in the wrong conclusion. Data should drive the changes in the system. • The pharmacy and medical departments must collaborate to identify other drugs that require important lab monitoring prior to dispensing. Expanding the list and actually executing the IA module may help eliminate some lab monitoring issues. • The facility must develop a system to document that the required monitoring occurs in accordance with facility requirements. The pharmacy director should seek guidance from state office in the proper use of the IA module. 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	The pharmacy department continued to implement changes in the Quarterly Drug Regimen Review process. A Quarterly Drug Regimen Review summary was now forwarded to the medical staff and RN case managers. The pharmacy director explained that involving the case managers was designed to improve accountability within nursing in regards to the case manager's role in ensuring that recommendations accepted by the medical staff were implemented and laboratory monitoring was appropriately completed. This was necessary because the various audits and reviews had identified problems with laboratory monitoring.	Noncompliance

	values.	The clinical pharmacist continued to notify 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. There were some difficulties encountered in conducting the review of this provision item. The monitoring team normally reviews the facility selected sample as well as a "random" sample. The random sample is essentially the QDRRs that are included in the active records as part of the review of section L. Only two of nine records provided to the monitoring team included the required QDRRs. A total of 20 Quarterly Drug Regimens Reviews were evaluated to determine compliance with this provision item. In accordance with state policy, the QDRRs included reviews of allergies, the appropriateness of medications, rationale for therapy, proper utilization, duplication of therapy, polypharmacy, drug – drug/food/disease interactions, and adverse reaction potential. The facility had adopted the lab matrix as the set of monitoring parameters for drug use. This required monitoring related to labs, vital signs, and other diagnostics associated with drug use. 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. A table listing all of the criteria for metabolic syndrome was included in the worksheets and the pharmacist indicated if the individual was at risk. Much of the information was included in the worksheets completed by the pharmacist. The comments section of the evaluations was not very extensive. Providers had to read the entire evaluation, including several pages of the worksheets to benefit from the information. Moreover, the quality of the QDRRs appeared to decline slightly since the last compliance review. The comments section appeared to be just a series of bulleted items often lacking clinical relevance. In several instances, important matters, such as recent hospitalization and ER visits related to allergies were never mentioned and they should have been. The following are a few examples of problems noted with the QDRRs reviewed: • Individual #881, 4/29/13: This individual was admitted to the hospital after experiencing angioedema related to ingestion of peanut butter. The QDRR was completed after this event noted the individual had a rash, but did not include the important finding of angioedema noted in the records. • Individual #754, 4/22/13: The individual was cited at being at risk for metabolic syndrome. This individual received multiple medications for management of diabetes mellitus, so the focus should have been on diabetes management and not risk. The risk threshold had been crossed.	

		• Individual #178, 3/18/13: This individual had an elevated prolactin level. There were no comments about possible causes or recommendations made for follow-up. The individual also was noted to have a health management plan for constipation, but there was no documentation of how often the suppositories were required. • Individual #587, 11/29/12: It was documented that there was an ADR on 11/27/12 secondary to carbamazepine, but no additional information or recommendations were provided. In addition to concerns related to content, the monitoring team was also informed by the pharmacy director that there were problems related to timely completion. During interviews, she reported that compliance for timely completion for the reporting period of months of October 2012 - to March 2013 was 70%. Data presented during the PET meeting conducted during the compliance review showed that for the month of April 2013, only 3 of 115 (2.61%) QDDRs were completed within the required timeframes. It was reported during the Pharmacy and Therapeutics Committee meeting that for the months of March, April, and May 2013, 293 QDRRs were completed. With a census of approximately 349, this represented completion of 83% of the required QDRRs. The monitoring team requested the dates of QDRR completion for all individuals living at the facility. The schedule provided was an excel spreadsheet that did not provide a realistic presentation of data and was therefore unusable. The monitoring team did note that several QDRRs reviewed involved delays of several weeks between pharmacy completion and review by providers. The failure to conduct the QDRRs within the required timeframes resulted in loss of substantial compliance for this provision item.	
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	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 presence of polypharmacy. Psychotropic polypharmacy and the Polypharmacy Oversight Committee are addressed in further detail in section J.	Noncompliance

	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 QDRR requires assessment of the entire drug regimen. To that end, the clinical pharmacist needs to note polypharmacy for management of conditions, such as seizure disorder and constipation in addition to psychotropic medications. <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 was no clear conclusion about the overall risk because multiple risk levels were checked. The comments were cursory. An individual who was at high risk for constipation would have noted that a bowel management plan was in place, but there was no indication if it was effective or how many suppositories or acute interventions were required. There were no recommendations on how to minimize the anticholinergic burden. Several of the QDRRs documented the findings of the MOSES and DISCUS evaluations, but this was simply listed as a number or a finding. <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. This was completed for individuals receiving new generation antipsychotics or who had other significant risks. Record reviews indicated that labs were not being completed in a timely manner. This was well documented by the facility and is discussed further in section N7. This provision remains in noncompliance due to the need to improve the monitoring for metabolic and endocrine risk, assessment of the anticholinergic burden, and address issues of polypharmacy.	
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. Moreover, this provision addresses the actual implementation of the recommendations by the providers. That is, providers who accept recommendations must take the actions, such as writing the appropriate orders that are required for successful order implementation. The facility found itself in substantial compliance with this provision citing that 100% of QDRRs were reviewed by both medical providers and 86.8% of the QDRRs showed that providers acknowledged and justified every recommendation. The self-assessment did not provide any metric related to the appropriateness of the actions of the prescribers beyond the point of accepting/rejecting the recommendations and documenting the decision. There appeared to be some gap in processes based on the statements from the pharmacy director. In fact, it was reported that the RN case managers were being sent the list of QDRR recommendations to ensure recommendations accepted by the PCP were carried out and monitoring was completed.	Substantial Compliance

		Clinical intervention and review of physician order logs indicated that the prescribers accepted the majority of recommendations made by the pharmacists prospectively. 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 remains in 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.	This provision item addresses the requirement to have, at a minimum, a quarterly evaluation of side effects completed by facility staff. Achieving compliance requires timely and adequate completion of the evaluation tools. Moreover, the intent of the evaluations is to provide clinically useful information. This provision item does not specifically address the pharmacy department's assessment of compliance with the requirement. The facility utilized the Dyskinesia Identification System: Condensed User Scale to monitor for the emergence of motor side effects related to the use of psychotropic medications. The Monitoring of Side Effects Scale was completed to capture general side effects related to psychotropic medications. While nursing conducts the reviews, the evaluation requires review and completion by a physician. 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, were reviewed. The findings are summarized below: Thirty four MOSES evaluations were reviewed for timeliness and completion: • 32 of 34 (94%) were signed and dated by the prescriber • 27 of 34 (79%) documented no action necessary • 7 of 34 (21%) evaluations lacked prescriber reviews • 5 of 34 (15%) evaluations documented delays of greater than 14 days between evaluator and prescriber reviews Twenty nine DISCUS evaluations were reviewed for timelines and completion: • 28 of 29 (96%) were signed and dated by the prescriber • 26 of 29 (90%) indicated no TD • 2 of 29 (7%) indicated the presence of TD • 1 of 29 (3%) was blank • 5 of 29 (17%) evaluations documented delays of greater than 14 days between evaluator and prescriber reviews Both evaluations were completed on a quarterly basis and data were maintained regarding the timeliness of completion. The facility reported, based on data extracted from QDRRs completed from October 2012 – March 2013, that the average compliance for timely completion for the reported rating period was 84.97%. Additionally, 30 active records corresponding to the same timeframe were also reviewed to determine if the evaluations were fully completed, inclusive of	Noncompliance

		the prescriber reviews. The results showed an average of 48% compliance with the requirements to complete the evaluations. The challenge of having the medical staff complete the evaluations at MSSLC was not a new one and has been noted in previous reports. Physicians received inservicing related to appropriate and timely completion and some improvement was observed. Staff turnaround was frequently cited as one cause, however, there was no correlation between the months with the lowest compliance scores and staff turnover. The monitoring team noted that noncompliant evaluations were completed by psychiatry staff, which was relatively stable. One change noted in the process was the implementation of the electronic version of the MOSES form through AVATAR. The monitoring team has a few concerns related to the implementation of this process: • MOSES is a validated standardized rating tool that assesses 10 areas. It was chosen by the state to serve as the standard tool for monitoring for side effects. It is one of many side effects rating tools. As a standardized tool, it is important that it is used it as it was designed to be used. That is, the electronic version should not exclude any information or sections. Otherwise, the facility is not completing the actual MOSES evaluation. • The form must include both sections of the prescriber review as well as a place for the prescriber to electronically sign and date. Finally, the monitoring team would like to emphasize the importance of utilization of this information. To various degrees, psychopharmacologic medications are associated with side effects. Monitoring for these side effects is important in individuals with developmental disabilities for many reasons, but is particularly important because many individuals cannot verbally communicate the presence of side effects. Staff must be vigilant in reporting adverse drug reactions, adverse drug events, and medication side effects. Staff must also ensure that the information is adequately communicated to the appropriate practitioners. 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. The facility will need to take a number of actions to move towards substantial compliance: • The MOSES and DISCUS forms must be executed as designed • The evaluations must be completed in a timely manner • The evaluations must be fully completed • The information must be utilized in clinical decision-making. • The data must be reviewed by the primary providers in addition to being reviewed by the psychiatrists and neurologists.	

<table>
<tr>
<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 additional requirements related to reporting, training, and completion of the intense case analysis. The pharmacy director was providing training in New Employee Orientation. However, it was not clear that all targeted staff received training. ADRs were discussed weekly 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><td colspan="10">Reported ADRs 2012 - 2103</td></tr>
<tr><td></td><td>July</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td></tr>
<tr><td>Number of ADRs</td><td>5</td><td>9</td><td>9</td><td>13</td><td>9</td><td>13</td><td>8</td><td>10</td><td>12</td></tr>
<tr><td>% Reported by Medical Staff</td><td>0</td><td>2</td><td>0</td><td>0</td><td>1</td><td>5</td><td>7</td><td>1</td><td>2</td></tr>
</table>

The number of ADRs reported each month was more consistent and this represented an improvement. It was clear during various discussions that the medical staff were concerned about the reporting of ADRs as opposed to side effects. Nonetheless, they were reporting more than previously noted. The majority of ADRs were related to the use of psychotropics and AEDs. Many of the ADRs were related to abnormal labs, such as white blood cell counts or liver enzymes. Several ADRs were manifestations, such tremors and extrapyramidal symptoms. In several instances, the summary data did not provide a clear outcome or plan for the individual. The following are a few examples:
• Individual #614, 7/9/12: Neutropenia /leukopenia likely due to aripiprazole. The plan was to continue to monitor the CBC.
• Individual #32, 7/18/12: Drooling/pooling associated with clozapine noted on MOSES 7/18/12. Continue MOSES/DISCUS monitoring.
• Individual #183, 8/2/12: Tremors secondary to Depakote. Inderal LA was started for tremors.
• Individual #202, 8/13/12: Breast swelling on 7/2/12 likely due to haloperidol or spironolactone. Continue MOSES/DISCUS monitoring.
• Individual #593, 9/6/12 tremors/shakiness, agitation noted on Moses 6/5/12 and 3/8/12 likely due to olanzapine and citaliprolam. Continue monitoring with MOSES/DISCUS.
• Individual #562, 10/19/12: Tremors on MOSES and DISCUS dated 8/9/12 and 7/9/12. Continue MOSES/DISCUS.
• Individual #178, 11/5/12: Possible olanzapine induced hyperprolactinemia. Prolactin 30 on 8/7/12; continue to monitor.

The facility continued to struggle with the completion of reviews of serious ADRs. For example, a case was reviewed for an Individual #994 who's absolute neutrophil count dropped to a critical level. The written case document provided to the monitoring team did not provide a date that the</td>
<td>Noncompliance</td>
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		review was completed nor did it indicate who was responsible for the review. The document did not actually state the reason for the review. The facility's policy for intense case review was based on a risk probability number. That concept was acceptable since it is simply a product of the likelihood that a real event occurred and the severity. However, failure mode effect analysis is a proactive evaluation and this review was retrospective. The intent is to conduct a more thorough review of serious ADRs inclusive of specific care issues, but also systems issues in a timely manner. The facility will need to review the ADR policy and the various levels of review required by policy. Not all ADRs requiring hospitalization require FDA reporting as indicated in policy. Additionally, in the case of death due to an ADR, a level of review higher that an intense case analysis would be warranted, as this would likely be classified as a sentinel event and also require a death review. Nonetheless, the facility will need to develop a format for conducting such reviews such as intense case analysis. Given that such reviews will only occur in the event of serious ADRs, there should be involvement of the QA department in this process. In order to achieve substantial compliance, the facility will need to take several steps related to the ADR monitoring and reporting system: • The reporting efforts should continue. A trigger list should be developed and provided to the dispensing pharmacists to assist in identifying ADRs at the time medication orders are processed. • The pharmacy director, as P&T Committee chair, should ensure that items requiring follow-up have the appropriate documentation of follow-up • The P&T Committee should continue reviewing ADR data, analyzing the data for patterns or trends, and developing preventive and corrective actions. 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. • 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 process for the ICA. Risk mitigation (FMEA) is always primary. Once the event has occurred and crosses the threshold, the facility must have a system in place to conduct a through review based on appropriate methodology. The goal is to conduct a through review of the circumstances and systems surrounding the event. This provision remains in noncompliance.	

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<tr>
<td>N7</td>
<td>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.</td>
<td>
The facility's DUE policy required completion of one DUE each quarter. DUE reports on risperidone and olanzapine were completed and presented in the Pharmacy and Therapeutics Committee meetings. A DUE on carbamazepine was presented at the P&T Committee meeting held during the week of the compliance review.

All of the DUEs were completed with the objective of ensuring the appropriate, safe, and effective use of the medications through the evaluation of monitoring and assessment of possible adverse drug events and suspected side effects.

The risperidone and olanzapine DUEs evaluated several parameters, including justification of drug use, drug dose, contraindications, side effects, lab monitoring, and clinical outcomes, such as psychiatric symptoms and restraint use. The indicators that had less than 70% compliance are presented in the table below.

<table>
<tr><td colspan="6">DUE Compliance Data
% Compliance</td></tr>
<tr><td></td><td></td><td></td><td>Metabolic Syndrome</td><td>MOSES/DISCUS</td><td>EKG</td></tr>
<tr><td>12/28/12</td><td>Risperidone</td><td>n=13 (20%)</td><td>69</td><td>69</td><td>54</td></tr>
<tr><td>3/26/13</td><td>Olanzapine</td><td>n=14 (20%)</td><td>50</td><td>21</td><td>50</td></tr>
</table>

The data indicated that there were problems with compliance in monitoring for metabolic syndrome, completing the MOSES and DISCUS evaluations, and obtaining EKGs for medication monitoring. As noted above, for the two evaluations, only 52% of individuals receiving new generation antipsychotics had a current EKG. The reports submitted to the monitoring team detailed a series of recommendations and corrective actions targeted at the deficiencies identified by the DUEs. Individual-specific and systemic corrective actions were taken. However, based on the data, the effectiveness of those actions was not clear because the results of the olanzapine DUE showed even lower compliance rates.

The pharmacy director presented the carbamazepine DUE during the P&T meeting conducted during the week of the compliance review. The objective was similar to that of the previous two DUEs. Seven of 25 individuals (25%) were reviewed. Monitoring parameters included justification, dose, and monitoring of labs and side effects. Data presented in the meeting indicated that six of seven (85%) individuals did not have labs (carbamazepine levels, CBC, LFTs) obtained every 6 months as recommended, but the results were in the record at the time of the DUE review.

Overall, the DUEs were well done and provided good information for the medical staff. The studies resulted in recommendations and corrective actions. The facility will need to monitor the effectiveness of the corrective actions to determine if improvement has occurred. Further guidance from the QA/QI department may be warranted if no clear improvement is demonstrated in the areas of concern
</td>
<td>Substantial Compliance</td>
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<table>
<tr><td></td><td></td><td>This provision remains in substantial compliance.</td><td></td></tr>
<tr><td>N8</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances.</td><td>The facility continued to report medication variances, but minimal progress was observed in this area. The medication data provided to the monitoring team are summarized in the tables below.

<table>
<tr><td colspan="13">Medication Variances 2012 - 2013</td></tr>
<tr><td></td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td></tr>
<tr><td>Nursing</td><td>63</td><td>78</td><td>63</td><td>74</td><td>42</td><td>106</td><td>76</td><td>59</td><td>55</td><td>43</td><td>45</td><td>103</td></tr>
<tr><td>Pharmacy</td><td>59</td><td>53</td><td>21</td><td>10</td><td>9</td><td>19</td><td>9</td><td>13</td><td>19</td><td>91</td><td>76</td><td>65</td></tr>
<tr><td>Provider</td><td>12</td><td>18</td><td>16</td><td>13</td><td>25</td><td>34</td><td>16</td><td>26</td><td>24</td><td>29</td><td>13</td><td>21</td></tr>
<tr><td>Total</td><td>134</td><td>149</td><td>100</td><td>110</td><td>76</td><td>159</td><td>99</td><td>97</td><td>98</td><td>163</td><td>134</td><td>189</td></tr>
</table>

The CNE chaired the Medication Variance Reduction Committee. The monitoring team attended this meeting during the week of the onsite compliance review to obtain a better sense of where the facility stood with its medication variance program. Data were presented on the total number of variances as well as the number of variances that occurred within each discipline. Salient observations and comments included:
• The CNE noted that the increased number of variances in March was largely due to one transcription error that resulted in 58 variances. This was due to the failure on the part of an RN to properly note an order.
• The pharmacy director presented data on pharmacy variances reporting that there was a significant increase that appeared to correlate to the use of contract pharmacists during the months of January 2013 through April 2013. Many of the pharmacy errors were actually due to the wrong medications being dispensed.
• The pharmacy director also reported problems with the nursing noting process. Delays in processing orders were frequent and the average delay was three days. This resulted in the possible omission of medications.
• While medical provider variances were recorded, there was very little discussion of this during the meeting. Data were presented on PCP error writing, but the significance of incomplete orders versus erroneous orders was not clearly presented. The pharmacy director referred the monitoring team to the document submission for clinical interventions and review of physician orders.

Several actions were taken to address the aforementioned areas of concern. Nursing was in the process of implementing a double check system for verification of physician orders. The pharmacy director also requested that nursing management evaluate the noting process due to order delays. Physicians were reminded of the importance of accurate and complete order writing. The pharmacy director had engaged the medical staff in an exercise during the P&T meeting designed to emphasize the importance of complete and legible physician orders.

During the Medication Variance Committee meeting, it was reported that on 6/5/13, two</td><td>Noncompliance</td></tr>
</table>

		medication variances were discovered. One involved a change in the dose of an AED for Individual #698. The order was written on 3/20/13. The nurse noted the order on 3/28/13, but the pharmacy reported that it was not received. The nurse who noted the order on 3/28/13 did not initiate a medication variance report at the time the order was discovered. The individual did not receive the appropriate medication dose and the error was not detected until 6/5/13. The medication variance form, provided to the monitoring team following the compliance review, indicated that the individual had no seizures since November 2012. It was clear throughout the week that the facility had many serious issues regarding medication practices that needed to be addressed. The monitoring team was particularly concerned that the medication error for Individual #698 occurred for more than two and a half months without detection. All individuals have quarterly assessments completed by medical, pharmacy, and nursing during which medications should be reviewed for accuracy. A review of the active record, which should be done to complete these assessments, should have revealed that the medication was not changed and the lab studies were not completed as ordered. In addition to this, nursing management described the process of medication ordering inclusive of the various checks and balances. It was acknowledged that the system(s) failed in this instance. The employee involved in this error was counseled. However, the magnitude of this event requires far more than a single employee action. This error which occurred over several months, resulted in the individual not receiving the proper dose of an AED and, therefore, put the individual at risk for a poor outcome. Changes in AED dosages, that did not occur as required, and were associated with poor outcomes have been noted in previous reviews. The monitoring team inquired about the systems that were implemented in the past as corrective actions in response to similar events. The systems that were repetitively involved in these failures must be thoroughly evaluated and the causes of the failures determined. Based on the variance data reviewed, reports of delays in receiving orders in the pharmacy, and other problems noted throughout this review, it was evident that the medication use system at MSSLC was faltering at many levels. Problems were identified in prescribing, transcribing, dispensing, administration, and monitoring. Thus, MSSLC had significant issues related to every step of the medication use system. Through discussion, interviews, and observations, the monitoring team learned of many interventions and actions that were implemented to address the deficiencies. However, there was no clear return on these efforts. The observation of the medication variance meeting indicated that the committee needed guidance in several areas from meeting structure to data use and analysis. At one point during the meeting, data were presented, but the committee members could not provide an explanation of the data to the monitoring team. Several issues seen during this review warrant further assessment and immediate remediation. However, MSSLC must have an overarching plan to address the problems of the medication use	

		system. The addition of processes/steps to a system that possibly lacks the infrastructure to support the weight of additional processes will not produce the desired outcome. Rather, the appropriate quality tools and methodology should be utilized to assess the status of the current system so that the next steps can be determined. This provision item remains in noncompliance.	

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 continued.
    b. 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.
    c. The facility will need to have documentation that the intelligent alerts occurred as necessary. The WORx system appears capable of providing a report of this. (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
    c. The facility must complete the QDRRs within the required timeframe
    d. Providers must complete the QDRRs within the required timeframe (N2).

3. The clinical pharmacist must assess all medication regimens for the presence of polypharmacy.

4. The clinical pharmacist should provide more clinically useful information with regards to the anticholinergic burden (N3).

5. The facility must address problems related to compliance with laboratory monitoring (N2, N4, N7)

6. 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).

7. 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 and Annual Medical Assessments (N5).

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

9. The facility should take multiple actions with regards to the ADR reporting and monitoring system:
    a. 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
    b. The process of the intense case analysis should be reviewed.
    c. Additional recommendations regarding potential policy revisions are contained in the body of report (N6).

10. 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).

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

12. The facility must address the issues outlined in the body of the report related to the medication variance system. It may be helpful to seek the assistance of the QA department is further assessing the facility's systems and problems (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 Physical Nutritional Management Policy 012.3 (3/4/13) o Reporting Choking Incidents Policy (4/15/13) and staff training records o PNMT Staff list, back-ups, and Curriculum Vitae o Staff PNMT Continuing Education documentation o List of Medical Consultants to PNMT o Section O Presentation Book and Self-Assessment o Section O QA Reports o PNMT Evaluation template o PNMT Meeting documentation submitted o Individual meeting Minutes submitted o PNMT Episode Log o List of individuals on PNMT caseload o List of individuals referred to the PNMT in the last 12 months o Documentation related to individuals discharged from the PNMT o Follow-up Tracker o Compliance Monitoring spreadsheet o Staff Competency-Based Training Spreadsheet o Staff Individualized Training Spreadsheet o Staff training records related to Individual #427 and Individual #60 o Documentation describing newly implemented Dining Room Procedures o Individuals with PNM Needs o Dining Plan Template o Compliance/Effectiveness Monitoring template o Completed Compliance/Effectiveness Monitoring sheets submitted o Adaptive Equipment Spreadsheet o PNMPC training curriculum and check-offs o Trend analysis documentation submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o Lists of individuals who completed PNM core competency training o Hospitalizations for the Past Year o ER Visits o List of individuals who cannot feed themselves

	o List of individuals requiring positioning assistance associated with swallowing activities o List of individuals who have difficulty swallowing o Summary Lists 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 Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with Pain 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 With Falls Past 6 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Individuals with Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted o PNMPs submitted o Documentation submitted related to choking events for: Individual #587 and Individual #375. o APEN Evaluations: Individual #518, Individual #407, Individual #528, Individual #61, Individual #84, and Individual #301. o PNMT Assessments and ISPs: Individual #38, Individual #395, Individual #588, Individual #577, Individual #314, Individual #171, Individual #518, and Individual #848. 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 #293, Individual #43, Individual #188, Individual #493, Individual #597, Individual #375, Individual #848, Individual #228, Individual #314, Individual #540, Individual #365, Individual #577, Individual #61, Individual #257, and Individual #143.

	o PNMP section in Individual Notebooks for the following: • Individual #293, Individual #43, Individual #188, Individual #493, Individual #597, Individual #375, Individual #848, Individual #228, Individual #314, Individual #540, Individual #365, Individual #577, Individual #61, Individual #257, and Individual #143. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #293, Individual #43, Individual #188, Individual #493, Individual #597, Individual #375, Individual #848, Individual #228, Individual #314, Individual #540, Individual #365, Individual #577, Individual #61, Individual #257, and Individual #143. <u>Interviews and Meetings Held</u>: o Jessica Barry, MS, CCC/SLP o Christian Sykes, RN o Heather Helton, OTR o Barbara Jones, RD, LD o Jennifer Capers, RD, LD o Various supervisors and direct support staff o ISP Meeting for Individual #278 <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas o Bathroom areas
	Facility Self-Assessment: The self-assessment completed by Jessica Barry, Habilitation Therapies Director, was a significant improvement over previous assessments submitted for this section. There were very clear and relevant activities conducted and most linked well to previous reports by the monitoring team. Findings reported were in measurable terms. Ms. Barry reported that due to her short time as director, she had to prioritize the focus of activities and this was reflected in the self-assessment. This was very appropriate as it was necessary to create a new structure for this process rather than build on an existing one. The format used was excellent. Each provision listed the activities to conduct the assessment, results of the self-assessment, a self-rating or analysis and actions executed to demonstrate attempts to move toward compliance were listed for each provision. Ms. Barry was on track to ensure continued progress. There was a significant improvement in the completion and quality of the PNMT assessments. Documentation could be tightened up for ease of locating information in the future, but in general, was very good. Benchmarks (in measurable terms) were not established as yet and this may be an area to consider for future self-assessment over the next six

	months for all elements of this provision. These benchmarks may be used to establish targets for success and to track progress. Though much continued work is needed, the monitoring team acknowledges the strides that Ms. Barry had made during the last six months. The facility rated itself as not in compliance with all eight items of section O. While the actions taken continue to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings.
	Summary of Monitor's Assessment: Progress was made towards substantial compliance with provision O. The PNMT was fully staffed, though there had not been a full team until January 2013. Only one of the members had participated on the team since the previous review. While the others were new to the SSLC system, they presented with excellent credentials and work experience in their respective fields. Back-ups had been identified for PT and attendance at the meetings held was consistent in 2013. A number of overdue comprehensive assessments had been completed and these were much improved. The meeting observed by the monitoring team was organized and the documentation greatly improved. Team members concisely and efficiently presented data for analysis and review relative to individual status. The PNMT appeared to be routinely and proactively reviewing individuals with a high risk of key PNM indicators. The status with regard to outcomes and exit criteria should be clearly established, routinely reviewed, and modified as needed to ensure that transition to the IDT occurred consistently. Documentation related to discharge should be clearly state the rationale and plan for transition to the IDT. Mealtimes and position and alignment were improved, though some issues positioning and transfers continued to be an issue. Some staff continued to lack confidence in their knowledge of key risk areas and the rationale for related supports they were responsible for providing. Monitoring of staff compliance must be consistent and effective. Monitoring should answer the following questions: • Are staff trained to do what is needed? • Are they routinely expected to do what is in the plan by supervisors? • Are staff doing the right thing even when they think no one is watching? A system of effectiveness monitoring was not well established and will be necessary for further progress with this provision. Areas, such as toothbrushing and oral sensitivity, should be addressed through assessment, supports, and monitoring. The therapists were encouraged to more objectively evaluate individuals for protective equipment. There were a large number of helmets, gait belts, staff assistance, protective boots, for example. The least restrictive options should be selected. Decisions related to equipment should be data driven.

	Samples for Section O: Sample O.1 consisted of a non-random sample of 15 individuals who were chosen from a list provided by the facility of individuals identified as being at a medium or high risk for or experienced an incidence of PNM related issues (i.e., aspiration, choking, falls, fractures, respiratory compromise, weight [over 30 or under 20 BMI], enteral nutrition, GI, osteoporosis), required mealtime assistance and/or were prescribed a dining plan, were at risk of receiving a feeding tube, presented with health concerns and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of the individuals who were assessed or reviewed by the PNMT over the last six months. Sample O.3 consisted of five individuals at SSLC who received enteral nutrition. Some of these individuals might also have been included in one of the other two samples.

#	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	Core PNMT Membership: The PNMT at MSSLC included the appropriate disciplines as defined in the Settlement Agreement. Each was a part-time team member who had other clinical and/or administrative duties, with the exception of the nurse, which was a full time position. Only Sandra Opersteny, PT had been a team member during the previous review. All others had been assigned during the last six months. (Jessica Barry, MS, CCC/SLP, Christian Sykes, RN, Heather Helton, OTR, and Barbara Jones, RD, LD). The new team members had start dates with the PNMT as follows: • Jessica Barry (9/17/12) • Heather Helton (1/2/13) • Barbara Jones (1/2/13) • Christian Sykes (12/1/12) Thus, this team had only been together for just over five months at the time of this review. Consultation with Medical Providers and IDT Members The following were listed as consultants to the PNMT: Christopher Ellis, MD (Medical Director), Admerle Hall-Hoskins, DO, James Gilley, MD, and Kyle Hamilton, MD, Michael Meyerson, MD, and William Thomas, PA. Others listed included nurse case managers, the Pharmacy Director, and the Respiratory Therapist. There was no physician in attendance at the PNMT meeting held during the week of this review. It was described as a review meeting rather than assessment and, as such, physician attendance was not necessary. There was no documentation of physician attendance, however, at PNMT meetings held over the review period.	Noncompliance

#	Provision	Assessment of Status	Compliance
	input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	<u>Qualifications of PNMT Members</u> The qualifications of the current PNMT members were as follows: 5 of 5 core team members (100%) were currently licensed to practice in the state of Texas, as verified online. There were several back-up team members identified (PT only) who also held current licenses to practice in their disciplines per online verification. 4 of 5 core PNMT members (80%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Others, while they did not have documented experience with individuals with developmental disabilities, each had extensive experience in their respective fields relative and applicable to PNM, documenting approximately 46 years collectively (five to 21 years). <u>Continuing Education</u> 4 of 5 PNMT core team members (80%) had completed continuing education directly related to physical and nutritional supports and transferrable to the population served during the past 12 months. Courses attended by the team members included the following: • KOTA Annual Conference 2012 (20 hours) • Rehab Cognitive Assessment and Management Basics (6 hours) • Senior Solutions Modality Training: Basics (6 hours) • Linking Nutrition to Mental Health (15 hours) • Development and Treatment of Eating Disorders (4 hours) • Wheelchair, Seating, Mobility and Positioning (Posture)- Use of the Scribbler ® to Digitize Custom Molded Seating Systems (1.5 hours) • Home Modifications (6 hours) • Geriatric Sensory Processing and Fall Prevention (6 hours) • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (11 hours) The nurse had only attended a two hour inservice at MSSLC related to the provision of OT services. While not within the last 12 months, the SLP had attended two extensive courses related to dysphagia in May 2012 for a total of 28 contact hours. The extent of continuing education obtained by this group of clinicians was extensive and commendable. Ongoing continuing education related to PNM and transferrable to the population served is essential to ensuring that an adequate level of expertise is	

#	Provision	Assessment of Status	Compliance
		maintained for all team members, individually and collectively via cross-training. <u>PNMT Meetings</u> Meeting minutes were submitted, dated 1/4/13 to 5/10/13, and 6/5/13. Documentation for meetings held prior to that time, since the last review was not available. During the time period for which documentation was submitted, the PNMT met 27 times prior to the week of this review. The team generally met at least one time weekly (13 weeks) and during seven other weeks, met two to three times each. There was additional attendance at IDT meetings as needed. Based on review of the minutes, attendance by core PNMT members for 27 meetings conducted during this time frame was: • RN: 89% attendance by core member, no back-up member, and 89% overall. • PT: 4% attendance by core member, 22% for back-up member, 26% overall. • OT: 85% attendance by core member, 0% for back-up member, and 85% overall. • SLP: 100% attendance by core member, 0% for back-up member, 100% overall. • RD: 81% attendance by core member, 11% for back-up member, 93% overall. Attendance was very good with the exception of the physical therapist. Assignment of back-up PT members should generally ensure improved representation in the future. There was no evidence of physician participation in any of the PNMT meetings. Previously, Dr. Ellis attended at least a number of these meetings, but with his assignment as medical director, this had not occurred at least since the first of the year. This section of provision O requires that the PNMP 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. Also, the PNMP is to be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. This aspect of O.1 is reviewed in O.3 below. It could not be determined if a fully constituted PNMT was in place throughout this review period, due to the lack of documentation prior to January 2013. Further, there was no evidence of physician consultation throughout this period. While attendance at the meeting is an excellent method to gain the input of the medical staff, alternate methods to demonstrate their availability to the PNMT is advised for compliance with this aspect of O1. Progress with this aspect of the provision was significantly improved, though since the changes were more recent (since January 2013), the monitoring team finds it in noncompliance at this time.	

#	Provision	Assessment of Status	Compliance
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>Identification of PNM risk</u> All individuals at MSSLC identified with PNM needs (198) were provided a PNMP, thereby ensuring that, as per the Settlement Agreement, each individual who could not feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who was at risk of choking or aspiration, collectively, "individuals having physical or nutritional management problems") were reported to be provided a current PNMP. There were 91 individuals identified with no PNMPs, though these lists did not match the current total census reported by the facility. Based on lists of individuals with identified PNM concerns, including those requiring positioning assistance associated with swallowing (47 individuals), who were dependent on others to eat (42 individuals), had difficulty swallowing (96 individuals), and/or considered to be at medium or high risk of choking (62 individuals) or aspiration (80 individuals), all but two of the individuals identified with one or more of these concerns were provided a PNMP (Individual #631 and Individual #715 were not listed as individuals with PNMPs despite both were considered at high risk for choking). • The facility reported that a choking incident for Individual # 631 was an isolated event. Because this individual received a regular diet and did not have PNM needs, he was not provide a PNMP. • Individual #587 had experienced two choking incidents requiring abdominal thrusts on 6/10/12 and suctioning and CPR on 3/29/13. Individual #587 was now deceased due to the second choking incident. • Individual #375 experienced one choking incident on 9/7/12, though abdominal thrusts were not required. Individual #375 was not listed at risk for choking and he did not have a PNMP to address this risk. Approximately 99% of individuals who presented with PNM concerns were provided a PNMP. The identification of other PNM concerns was via the at-risk system implemented at the facility. Improvements were noted in the completion of the risk rating tools. Action plans were not provided in the same manner as during the previous review. Rather, the plans to address specific health risk issues were included in the IRRF and IHCP, both integrated plans developed collaboratively with IDT members. <u>PNMT Referral Process</u> The PNMT received some referrals from the IDTs, though some individuals followed by the team were self-referrals. From 7/3/12 to 5/1/13, there were 21 individuals referred to the PNMT. It could not be determined how many of these were self-generated. The	Noncompliance

#	Provision	Assessment of Status	Compliance
		dates listed were not always consistent with the individual minutes submitted for the individuals (Individual #314, Individual #577, and Individual #98) and none of these contained information prior to January 2013/end of December 2012. There were 10 individuals on the current active caseload for the PNMT as of 5/20/13. Reasons for referral were not known to the monitoring team because they were not requested. This could not be determined because most had been referred prior to January 2013 and documentation related to those referrals was not submitted. Criteria for IDT referral were included in the state policy, Physical Nutritional Management (012.3), effective 3/4/13 as follows: • Two choking incidents in one year • Two aspiration pneumonia diagnoses in one year • Results of PNMT nurse Post-Hospitalization Assessment for individuals diagnosed with any of the following: a. Aspiration Pneumonia b. GI Issues c. Fractures d. Skin Integrity e. Seizures • New or proposed enteral feeding • Unresolved vomiting (>3 episodes in 30 days not related to viral infection) • Significant/unplanned/verified weight loss or gain of: a. 5 pounds in one month b. 3 or more pounds per month for 3 consecutive months, or 7.5% of body weight for 3 consecutive months c. 10% if body weight in 6 months • Any stage III or IV decubitus, or any stage II with delayed healing • Fracture of a long bone, spine, or hip While these were developed as guidelines for the PNMT, other individuals may be followed as deemed necessary by the team. Specific risk areas were tracked by the team based on data derived from a variety of sources and entered into the PNMT Episode Log. This practice was intended to identify needs for supports and interventions early, rather than waiting for significant health issues to occur before action was taken. Issues tracked included the following: • BMI ≤20 • BMI ≥30 • Weight loss/gain of 10% in six months • Weight loss/gain of 7.5% in three months	

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		• Weight loss/gain of 5% in one month • Pneumonia (Bacterial, Aspiration, or recurrent Aspiration defined as two times in 12 months, and/or unresolved aspiration triggers) • Decubitus ulcers (Stage II, III, IV, unstageable and/or delayed healing) • UTI • Poor oral hygiene • Feeding tube clogged • New enteral nutrition • MBS • Risk for enteral nutrition • Emesis • Choking • Fracture of long bone, pelvis, spine • Other relating to PNM status There did not appear to be clearly established thresholds for intervention related to these PNM-related risk areas. A PNMT meeting was observed by the monitoring team. No other IDT members were present. The PNMT had significantly improved its method of documentation. There was a projector available for use, allowing the documentation to be readily available to all team members throughout the meeting. This meeting was intended to conduct status reviews of individuals on the PNMT caseload. It was conducted efficiently, yet the discussion was thorough. The facility should address facility trending of occurrence of PNM-related concerns as well as others, for specific individuals, facility wide, and over time. Collaboration across departments was indicated, including incident management, risk management, QA, and others. This is another area where specific benchmarks may be tracked in an effort to reduce the occurrence of some of these key indicators. <u>PNMT Assessment and Review</u> • 6 of 7 PNMT assessments submitted (86%) were initiated at a minimum within five working days of the referral. The referral for Individual #577 was on 12/31/12, but the assessment was not initiated until 1/17/13. There was no rationale for this delay. This was, however, a significant improvement from the time of the previous review by the monitoring team. • 5 of 7 PNMT assessments (71%) were completed in less than 30 days of the referral. The referral for Individual #588 was on 12/18/12, but the assessment was completed on 3/4/13, over two months later. There was no rationale	

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		provided for this delay. As stated above, the referral for Individual #577 was on 12/31/12, yet the assessment was completed on 3/12/13, again well over two months later with no rationale for the delay. The assessments completed by the PNMT should be comprehensive, including specific clinical data reflecting an assessment of the individual's current health and physical status, with an analysis of findings, recommendations, measurable outcomes, monitoring schedule, and criteria for discharge. Based on review of the assessments in the last two months as requested, the comprehensiveness of the PNMT assessment components was as follows: • 7 of 7 (100%) contained date of referral by the IDT (or self-referral). Each included the reason for referral, though it was not always clear the origin; • 7 of 7 (100%) contained date assessment was initiated; • 7 of 7 (100%) contained evidence of review and analysis of the individual's medical history; • 7 of 7 (100%) identified the individual's current risk rating(s), including the current rationale, at least in part. Those listed in the assessments were deemed relevant to the reason for referral, while others were deemed unrelated and, as such, were not addressed. PNM is a comprehensive approach to the assessment and provision of supports and services to address an individual's health concerns. Individuals with significant needs that warrant referral to the PNMT typically have complex issues that are interrelated and should be evaluated with regard to this interrelatedness. Antecedents to concerns in one area may result in health changes in other areas and should be addressed in that context. Some examples included the following: o Individual #588: He was referred related to aspiration pneumonia. The risk issues deemed relevant were related to choking, aspiration, respiratory compromise, gastrointestinal, and weight. Per the assessment, his IDT also had identified that he was at high risk for falls, challenging behavior and polypharmacy/side effects. Challenging behaviors and polypharmacy/side effects may have been relevant, but were disregarded. While falls were not necessarily directly related to aspiration pneumonia, falls may be an indication that he was experiencing side effects from medications. Each of these could factor into possible aspiration and secondary aspiration pneumonia. These should be evaluated by the team and addressed or ruled out. o Individual #577: He was referred for recurrent pneumonia. The risk factors considered relevant by the PNMT were limited to aspiration, respiratory compromise, and infections. He had two episodes of pneumonia in a three month period. The first was on 9/4/12 and the	

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		second was on 11/27/12, after surgery for a sebaceous cyst (10/17/12). Skin integrity, and constipation/bowel obstruction were not considered relevant though he was identified by his IDT at medium risk. Also, it was noted that he had experienced a downward trend in his weight recently, but this was not a risk area the PNMT considered relevant. One important purpose of the PNMT, is to model for IDTs that they must consider all factors when addressing health concerns. Typically, only the obvious is addressed, which often leads to a failure to identify the root cause or failure to recognize how clinical indicators are interrelated. It also helps in establishing a baseline of health prior to PNMT supports and services in order to evaluate changes and improvements. The PNMT should consider each of the current risk ratings and determine if the individual's clinical indicators were consistent with the IDT's ratings of risk. If the PNMT looks only at those factors that are medium or high, they may overlook a key factor for an individual that both the IDT and, subsequently, also the PNMT did not recognize as significant. The PNMT may not know what risk areas were actually relevant until after the gathering of data and the analysis to establish a rationale for necessary supports and interventions. An example of this was noted for Individual #518. The only risk areas considered to be relevant and reported were gastrointestinal, circulatory, weight, diabetes, infections, and skin integrity. The excellent analysis provided by the team in their report dated 5/6/13, identified that 14 medications she was prescribed had side effects for diarrhea and/or constipation, both of which she was reported to experience and each complicated healing of the wound on her coccyx for which she was referred. It appeared that she might also be prone to UTIs due to the complexity of her health status at that time. Polypharmacy, constipation /bowel obstruction and UTIs were not listed as relevant per the PNMT assessment. • 5 of 7 (71%) included recommended risk ratings based on the PNMT's assessment and analysis of relevant data. These were not clearly identified in the assessments for Individual #577 and Individual #588; • 0 of 7 (0%) contained evidence of discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition. It was not clear if or how behaviors (including those classified as challenging) impacted health and the provision of PNM supports and services. In the cases that these do not have a particular impact, this should be stated; • 2 of 7 (29%) contained assessment of current physical status though these were only partial (Individual #588, Individual #38, and Individual #518). Typically the PNMT only reported the findings of others. There was no evidence of a nursing physical examination, for example, in any of the assessments reviewed. • 2 of 7 (29%) contained assessment of musculoskeletal status; • 2 of 7 (29%) contained evaluation of motor skills;	

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		• 1 of 7 (14%) contained evaluation of skin integrity; • 4 of 7 (57%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, or indicated that the individual was independent with mobility and repositioning. There was no evidence that the PNMT addressed positioning that may impact PNM status including during bathing and oral hygiene. A bathing assessment was completed for Individual #395 prior to referral to the PNMT and was documented in the PNMT assessment, but there was no evidence that the PNMT conducted one for their assessment; • 5 of 7 (71%) contained evaluation of current adaptive equipment; • 3 of 7 (43%) contained nutritional assessment, including but not limited to, history of weight and height; intake, nutritional needs, and mealtime/feeding schedule; • 1 of 7 (14%) contained evaluation of potential or actual drug/drug and drug nutrient interactions. All identified potential side effects of prescribed medications, though most, with the exception of Individual #518' assessment did not address actual or suspected side effects, or rule this out if it was not an issue. None seemed to address drug/nutrient interactions; • 0 of 4 (0%) identified residual thresholds, if enterally nourished; • 4 of 7 (57%) contained a tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation; • 0 of 7 (0%) contained information about the individual's current respiratory status based on a physical assessment that included, but not limited to, respiratory rate, heart rate, lung sounds, breathing patters, or oxygen saturation levels. Some of these were addressed in a HOBE for Individual #588, though no baseline information was provided in sitting or supine, for example, as previously established by nursing; • 4 of 7 (57%) contained evidence of review/analysis of lab work, though how this was done was inconsistent; • 7 of 7 (100%) contained evidence of review/analysis of medication history over the last year and current medications, such as dosages, administration times, and side effects. Changes in medications and/or doses were not reported consistently with the exception of Individual #98, nor was the start date for current medications prescribed; • 7 of 7 (100%) contained discussion as to whether existing supports were effective or appropriate; • 1 of 7 (14%) contained oral hygiene status. None documented observation of oral hygiene/toothbrushing by the team, though the assessment for Individual #314 reported providing staff training related to use of the Plak Vac. Four individuals were referred related to aspiration pneumonia. Not only is oral hygiene status an important element to consider, position and other techniques related to	

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		toothbrushing should also be investigated to rule out any concerns that potentially increased the individual's risk of aspiration; • 0 of 7 (0%) contained evidence of observation of the individual's supports at their home and/or day/work programs; • 3 of 7 (43%) contained evidence that the PNMT conducted hands-on assessment; • 7 of 7 (100%) identified the potential causes of the individual's physical and nutritional management problems; • 7 of 7 (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rational for the recommendations; • 0 of 7 (0%) contained recommendations for measurable skill acquisition programs, as appropriate; • 0 of 7 (0%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; • 0 of 7 (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. The outcomes were identified, but only criteria for re-assessment were outlined rather than clinical indicators for when nursing staff should contact the PNMT. The criteria for re-assessment or review were often occurrences of negative outcomes (such as additional fracture, for example), rather than specific indicators that may require attention prior to actual occurrences; • 4 of 7 (57%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); • 5 of 7 (71%) contained recommendations for monitoring, tracking or follow-up by the PNMT; and • 5 of 7 (71%) contained signatures of all core team members (or alternate) with dates. Physician signatures were also noted for each of the PNMT evaluations. Compliance with each of the 31 elements outlined above was 100% for 26% of the elements. All others were at or below 70%. Though continued improvement was needed, there had been a significant improvement from the previous review. There were measurable outcomes, monitoring schedules, criteria for discharge and criteria for review/re-assessment outlined in 6 of 7 assessments reviewed. The review interval by the PNMT was 30 days for each of these individuals. The criteria for review were not related to key indicators, but rather equivalent to the criteria for referral by the IDT. For example, two episodes of aspiration pneumonia in one year for Individual #588, Individual #577, Individual #38, Individual #98, and Individual #314.	

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		It was of concern that even a single occurrence of aspiration pneumonia, or perhaps another respiratory event would be acceptable without follow-up and review by the PNMT because this may be an indication that the plan developed was either not implemented as intended or was ineffective. Objective clinical indicators should be established for individuals followed by the PNMT as part of the assessment recommendations that may serve as clues for potential change in status. These should be integrated into the individuals' IHCPs, as well as, clinical data that individually define health and wellness. The IHCPs for individuals with physical or nutritional management difficulties require effectiveness monitoring to assess the individuals' status and the impact of interventions and supports. Effectiveness monitoring requires monitoring of these individual-specific objective clinical data to determine the efficacy of the IHCPs interventions (of which PNMT interventions are a part). PNMT review would be necessary to determine if the plan was being implemented as written, staff were adequately trained, etc. In cases that the team determined interventions were not effective, the IDT/PNMT should revise these interventions. Plans should be revised within 24 hours, or sooner if the concern was critical, when a change was indicated. This should be collaborative between the PNMT and the IDT. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u> In some cases, the recommendations were in various sections throughout the assessment rather than in one section at the end (Individual #314). This was not a user friendly format and could result in the IDT overlooking a key element to the plan. Consideration to modify this was indicated. The following was noted related to integration of PNMT recommendations: • For 4 of 7 individuals (57%) for whom assessments were submitted in the last two months, all recommendations by the PNMT were addressed/integrated in the ISP/ISPA, IRRFs, and IHCPs. The accuracy of recommendations for Individual #395 was not 100% and were not always consistent with the PNMT evaluation. The updated IRRFs and IHCPs associated with the recommendations from the PNMT assessments were not included in this submission. • In 4 of the 7 plans reviewed (57%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. Discharge criteria were also identified as well as criteria for re-assessment by the PNMT. • In 1 of the 7 plans reviewed (14%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In 3 of the 7 individual's plans reviewed (43%), the plans included the specific clinical indicators of health status to be monitored. • In 0 of the 7 individual's plans reviewed (0%), the plans defined individualized	

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		triggers. • In 7 of the 7 individual's plans reviewed (100%), the frequency of monitoring was included in the plans. Individual-specific monitoring was outlined in the four plans documented in an ISPA submitted, as well as 30 day review by the PNMT. Others did not specify this. <u>PNMT Follow-up and Problem Resolution</u> It was difficult to track implementation of the recommendations based on the documentation submitted. While the documentation was much improved from the previous reviews, a system that addressed implementation of recommendations and other actions should permit the team and others to readily review this information. The individual minutes appeared to be a logical place to do this, but the monitoring team found this difficult. Review of the meeting minutes for a specific individual would prove to be time intensive. These are not accessible to all IDT members in the active records. Updates related to the status of recommendations for the 30-day review for Individual #38, for example, were addressed in the PNMT meeting minutes on 5/9/13. Many of these had not yet been addressed by the IDT at that time. Another 30 day follow-up was conducted on 6/5/13 at which time it was noted that the MBS recommended by the PNMT was deemed to be not necessary by the primary SLP though no rationale was given. Further, two additional recommendations were as yet not addressed at that time. There was no statement as to the status of the other previously outstanding recommendations at that time. Much of what was documented in the meeting minutes was not included in his individual minutes. It was of concern that the PNMT follow-up was limited to 30 day intervals. The urgency of interventions and actions for individuals whose health status warranted referral to the PNMT should carry over to the implementation of actions recommended by the PNMT. In the case that the IDT and PNMT reached consensus that a particular recommendation was not necessary, there should be a clearly documented rationale in order to close the loop on those issues. <u>Individuals Discharged from the PNMT</u> There were 15 individuals discharged from the PNMT during the last six months: • Individual #61 • Individual #477 • Individual #314 • Individual #528 • Individual #293 • Individual #266 • Individual #84 • Individual #375	

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		• Individual #533 • Individual #541 • Individual #341 • Individual #188 • Individual #540 • Individual #588 • Individual #518 A discharge summary should be completed that provides objective clinical data to justify the discharge. This may be via a report or IPN by the PNMT. All outstanding recommendations should be integrated into the IHCP with specific criteria established for referral back to the PNMT. An ISPA should be held to discuss the terms of discharge. The ISPAs were not submitted for all individuals, but for 8 of 15 individuals there was at least an IPN or PNMT consult stating that they would be discharged from the PNMT. In the case of Individual #477, she was seen for a suction toothbrushing assessment on 1/18/13. Recommendations included that nursing would actually conduct this assessment and that she was discharged from the PNMT. There appeared to be a subsequent referral to the PNMT secondary to falls with a serious injury. On 4/22/13, the PNMT documented that she was being transferred to Richmond SSLC and thus discharged from the PNMT at MSSLC. Individual #188, Individual #293, Individual #540, Individual #61, Individual #314, and Individual #375 were included in Sample O.1 and the documentation related to their discharges from the PNMT was as follows: • Based on review of their documentation, for 1 of 6 individuals, there was a clearly documented ISPA to document that they had been discharged from the team. • The ISPA for Individual #375 (2/15/13) documented review of his initial evaluation and stated that all supports were in place and that he was not ready for a lifestyle change relative to weight loss, but stopped short of stating he was discharged from the PNMT. An IPN by the PNMT on 2/15/13, did state that he was discharged, but did not provide the rationale for this. • PNMT consults designated discharge from the PNMT related to suction toothbrushing for Individual #293 and Individual #314. There was no evidence that an ISPA was held to discuss this. • There was no documentation related to discharge from PNMT for Individual #61. • Additional documents, referred to as PNMT Meeting Minutes that referenced discharge and summarized the status of actions, were submitted to the monitoring team for Individual #188 and Individual #540. There were IDT signature sheets submitted possibly representing the ISPA, though neither clearly stated that the individual was discharged from the PNMT. A separate IPN designating discharge was noted for Individual #540.	

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		As stated in previous reports, an effective PNM program requires that the referral to the PNMT must occur in a timely manner, so as to capitalize on the collective expertise of the team members. There is an urgency to complete PNMT assessments. Even so, some interventions may need to be implemented immediately, before the written report is finalized. It is critical that the assessments be completed in a timely manner because these individuals present with significant identified needs for supports and services to address PNM health concerns. At this time, the MSSLC PNMT appeared to understand this responsibility and the assessments were conducted in a very timely manner, a significant and important improvement from previous reviews. The team is commended for its hard work, expertise, and follow-up. That being said, consideration should be given to individualize follow-up at more frequent intervals. In some cases, the IDT had failed to completed specific key actions related to the recommended and agreed upon plan. This was not known until the 30 day follow-up. That being said, the PNMT was clearly moving substantial toward compliance with this aspect of O.2.	
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>Identification of Individuals Requiring a PNMP</u> In Section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team, as appropriate. Per current state office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. Attendance by key IDT members for review and approval of the PNMP included the following current ISPs with signature sheets (15/15 ISPs included signature sheets): • Medical: 20% (3/15) • Psychiatry: 7% (1/15) • Nursing: 100% (15/15) • RD: 27% (4/15) • Physical Therapy: 47% (7/15) • Communication: 47% (7/15) • Occupational Therapy: 40% (6/15) • Psychology: 73% (11/15) • DSP: 93% (14/15) • Dental: 0% (0/15) • Pharmacy: 8% (1/15)	Noncompliance

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		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 unless each of the team members is present to participate in that process. The new pre-ISP process will identify which team members are required to attend the ISP meeting and the needs for review of the PNMP should be considered when making this determination. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample O.1: • PNMPs for 15 of 15 individuals (100%) were current within the last 12 months. The format of the plans varied slightly in that some were printed vertically and others were printed horizontally. Consistency with this may be helpful to DSPs to readily recognize the PNMP. This was a decrease from 91%. • PNMPs for 15 of 15 individuals (100%) included a list of PNM risk levels. In some cases, only high risk areas were listed and for others, both medium and high risk areas were included. Outcomes were also stated in the plans. It was understood by the monitoring team that state guidelines related to the PNMP format had changed and that this was not consistent with those changes. This was consistent with the previous review. • In 5 of 15 PNMPs (33%), there were large and clear photographs with instructions. The photos were presumed to be in color in the plans available for staff use. The absence of photos was confusing as at least eight of the others had equipment or special techniques listed that would likely require photographs. This was an improvement from 0%. • 13 of 13 PNMPs (100%) identified the assistive equipment required by the individual, though rationale or purpose was not consistently identified. There was a specific section that listed the adaptive equipment in some cases (Individual #293), and for others it was included only in various sections throughout the plan (Individual #143). • In 15 of 15 PNMPs (100%), positioning was adequately described per the individuals' assessments or the individual was described as independent. This was consistent with the previous review. • In 15 of 15 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. This was consistent with the previous review. • In 15 of 15 PNMPs (100%), bathing instructions were provided. This was a significant improvement from 0%.	

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		• In 14 of 15 (93%) PNMPs, toileting-related instructions were provided, including check and change. This was an improvement from 74%. • In 0 of 15 (0%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. • In 15 of 15 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was consistent with the previous review. • 14 of 14 individuals' (100%) Dining Plans were current within the last 12 months. As per the OT/PT assessment dated 8/8/12, the Dining Plan was discontinued for Individual #493 due to his safe and independent mealtime skills. • 5 of 15 individuals had feeding tubes with no oral intake. 4 of 5 PNMPs/dining plans (80%) indicated the individual was to receive nothing by mouth. Individual #143 received oral intake of food, with tube use for medication and meal refusals. This was an increase from 64%. • In 7 of 14 PNMPs/dining plans (50%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. This was an improvement from 0%. • In 10 of 10 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. This was consistent with the previous review. • In 9 of 10 PNMPs/dining plans for individuals who received liquids orally (90%), the liquid consistency was clearly identified. This was a decrease from 100%. • In 4 of the 10 PNMPs/dining plans for individuals who ate orally (40%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular dining utensils. There was generally a rationale offered for the equipment listed. Consistent with the previous reviews, however, the plans did not specify regular utensils. • In 15 of 15 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. This was consistent with the previous review. • In 15 of 15 PNMPs (100%), oral hygiene instructions were included. Most contained information regarding positioning, frequency and/or specialized instructions. This was an improvement from 61%. • 5 of 15 PNMPs (33%) included information related to communication (how individual communicated and how staff should communicate with individual). Some merely stated that the individual was verbal and others only referenced the communication dictionary. This was an improvement from the previous review when none (0%) of the plans identified strategies for communication partners.	

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		The PNMPs reviewed were generally very good with very comprehensive content. PNMP audits were conducted and attention to the areas described above will ensure greater consistency and improved content.	
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>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u> Dining Plans were readily available in the dining areas. General practice guidelines (foundational training) with regard to transfers, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in NEO and in individual-specific training by the therapists and PNMCs. Based on observations conducted by the monitoring team, it was noted that: • 35 of 41 individuals' (85%) dining plans were implemented as written. • 39 of 54 individuals' (72%) positioning plans were implemented as written. Based on additional observations: • 1 of 3 (33%) individual's oral hygiene plans were implemented appropriately. Staff did not brush for an appropriate length of time and head alignment was not adequate. • 1 of 5 (20%) individuals' transfer plans/repositioning were correctly. No bathing was observed, so the following metric did not apply: • ___ of ___ individuals' bathing plans were implemented as written. <u>Choking/Aspiration Events</u> There were 12 individuals identified at high risk for choking and 50 others were considered to be at medium risk. There were three choking incidents reported in the last six months. Two of these were for one individual. One required abdominal thrusts, one did not and the third of these resulted in death. The SLP conducted a consult following choking incidents that occurred on 6/10/12 and 9/6/12. These consults were conducted on 6/12/12 and 9/7/12. Follow-up to a choking incident should occur by the next meal in most cases, and no more than 24 hours if actions had been taken to modify diet texture, for example. Other issues associated with the third occurrence of choking reported were identified by the facility as inadequate supervision by staff, a small, crowded dining room, and an unorganized mealtime process. Subsequently, the choking policy was revised effective on 4/15/13 (though staff reported that this was in process prior to this event), staff were trained (approximately 532), and the dining areas were assessed and analyzed to adjust the flow and process used for mealtimes. For example, meals were currently completed in smaller shifts to ensure that there were adequate staff available to attend to those eating	Noncompliance

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		at any given time. Staff were directed to be seated at the tables and were not to leave the table until all individuals were finished eating. Additional staff served as a runner to obtain additional food or equipment and to remove dirty dishes and utensils. The new policy clarified the definition of choking and outlined the procedures required in the event that a choking incident occurred. There was some confusion with regard to these, however. Choking itself was defined as a partial or complete obstruction of the airway. Further, a "choking incident resolved with assistance" versus a "coughing with signs of struggle" was defined. However, the statement of procedures referred to choking incidents (whether resolved with or without assistance). It was not clear what a choking incident resolved without assistance was as this was not defined, nor was it clear if the procedures related to an incidence of "coughing with signs of struggle." Many staff continued to require prompts to answer questions related to risks, though others did an excellent job of describing the individual's risks and could explain why they had a modified texture or liquid consistency, or required a special spoon or mealtime strategy. Most immediately indicated that they needed to look at the plan in order to answer questions, but when prompted, they were able to provide the answers accurately. Review of the plans and risks should be done when the staff were initially assigned for the day, but even so, staff should have an active knowledge of the individuals to whom they were assigned on any given day: • The staff were assigned as responsible for the individual. • The staff should have already reviewed the plan prior to taking on that responsibility. • The staff should be trained to competency to work with that individual. • Staff should know many, if not most, of the risks and rationale for the supports they provide. It is critical that they know what to look related to potential triggers or clinical indicators so that any necessary action may be taken promptly. While there was clear progress in this area, there continued to be a number of errors with key elements of the plans, particularly related to positioning, transfers, and repositioning. Error rates as reported by the facility were low, but did not take into consideration which elements were not in compliance. Some elements were essential, however, when tracked in this manner, equal weight was given to all.	
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	<u>NEO Orientation</u> Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. Class time was extended since the previous review to address the PNMP, orientation and mobility, communication/deaf awareness and AAC, lifting and transfers, and dining plans and eating skills. It was reported that there was a presentation of foundational skills, with modeling by the trainers to new employees. Practice time was	Noncompliance

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	nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	provided with coaching by the trainers and then new employees were checked off on each skill, using the checklist, outside of the classroom, by the professional staff with assistance from the PNMPCs and habilitation therapy technicians. There were 10 core competencies including: • Mechanical lift • Stand pivot transfer • Gait belt use • Two person manual transfer • Bed positioning • Positioner and wheelchair positioning • Mealtime safety • Simply Thick • Adaptive dining equipment • Communication If the new employee failed to demonstrate competency, the check-off was discontinued and re-training and coaching were provided. A mentoring process provided an opportunity for the PNMPCs to address individual-specific training for new employees assigned to a home during a three hour block. There was no consistent method to establish and maintain competency for staff who provided the training. There was no system to audit the trainers at the time of this review. NEO training was provided by licensed therapists with assistance from PNMPCs. The PNM-related core competencies (i.e., foundational skills), included in the NEO training was comprehensive. There were extensive associated skills-based competency check-offs for most of this content. <u>PNM Core Competencies for Current Staff</u> Refresher courses for all existing staff were required annually for lifting and transfers only. Skills-based competencies were also required for this. Consideration for additional refresher courses across more of the core PNM competencies should be considered, particularly in the areas of mealtime and communication. These are areas of support that are provided to every individual living at MSSLC, and as such, staff should be provided more extensive and ongoing training to ensure that competency of performance in these areas is maintained. After numerous requests that the PNMPCs be provided with training based on an established curriculum to establish their competency for core PNM content, monitoring and training, a curriculum was finally completed and the training conducted. This training	

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		clearly outlined their roles and responsibilities, essential job functions, and other job requirements related to communication skills, writing skills and interactions with others. The content included all key areas of PNM, and a task analysis for each core job function was clearly outlined, forming the basis for competency check-offs. The new director and the PNMPC supervisor are commended for making this a priority and ensuring that this critical training was finally developed and provided to the PNMPC staff.	
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>Facility's System for Monitoring of Staff Competency with PNMPs</u> MSSLC utilized the Universal Compliance Monitoring Form developed by the state. The elements of the form were very general and it made it difficult to identify more discrete issues for tracking and analysis. For example, the form stated that "materials/equipment are present, working and utilized." If there was a "no" finding, there was no method to clearly identify which of these had been a concern. This was also true of a number of other elements monitored. A monitoring form that included more discrete measures should be considered, so that specific issues could be more readily identified for individual and/or systemic change. There was no clearly established frequency to conduct staff compliance monitoring. While the department had the ability to track staff names, these were not used to ensure that all staff were routinely monitored. It was likely that some staff were not monitored routinely for continued compliance plans for which they were deemed to be competent. The monitoring team requested compliance monitoring forms completed in the last month by OT and PT and monitoring forms completed for individuals included in Sample O.1 for the last three months. There were 122 Compliance Monitoring Forms submitted and 95 PNMP Monitoring Forms submitted for 14 of the 15 individuals in this sample. There were no monitoring forms provided for Individual #98. These two forms differed somewhat. The PNMP Monitoring Form contained more elements, while the Compliance Monitoring Form contained a system to calculate a compliance score. Compliance Monitoring designated a time that the monitoring had occurred and a description of the activity monitored; the other form did not. Both contained a mechanism for follow-up related to issues identified during the monitoring. All of the PNMP Monitoring Forms had been completed in December 2012 and January 2013, while each of the others was completed from February 2013 through April 2013. It appeared that the PNMP Monitoring Form had been discontinued and the Compliance Monitoring Form had been implemented as of February 2013 per the action plan.	Noncompliance

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		Compliance monitoring was completed as follows: • 24 forms (18%) were marked as completed between 2:00 pm and 8:00 pm. • 42 forms (6%) were completed between 12 noon and 2:00 pm. • 44 forms (69%) were completed between 8:00 am and 12 noon. • 2 forms (0%) were initiated prior to 8:00 am. Four other forms for the same individual (Individual #293) were completed between 6:00 and 7:00, but AM or PM was not identified. • 6 forms had no time designated. Compliance scores were calculated for only 39% of the forms submitted. Only 12 (10%) of the forms identified any "no" responses, indicating that a concern was noted. This did not appear to be consistent with general observations by the monitoring team. Documentation of actions related to these was inconsistent on the forms. The PNMP monitoring process did not consistently cover all areas that were likely to provoke swallowing difficulties or increase PNM risk, including bed position, bathing, medication administration, and oral care, though some of these were noted. In most cases, the monitor did not identify the position the individual was in at the time of the observation. Monitoring was conducted as follows: • Mealtime: 21 • Positioning: 35 • Adaptive Equipment: 20 • Positioning and Adaptive Equipment: 3 • Lifting /Transfers: 8 • Oral Care: 5 • Medication Administration: 3 • Communication: 7 • Snack: 1 • Behaviors: 1 (it was not clear why this was monitored by a PNMPC) • Mobility: 10 • Bathing: 5 • No designation: 3 Though monitoring occurred across a variety of activities and times of day, it was not clear how these were determined. Previously, there had been an elaborate schedule developed, but the amount of monitoring was determined to be excessive, and this had been cut back. It was not clear as to how these were scheduled at this time. There was consistent trending of the findings from monitoring, though the only aspect reported was related to compliance monitoring conducted by professional staff.	

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		Compliance scores from 1/15/13 to 4/30/13 was 97% and that only 12% required corrective action related to the findings. These scores appeared to be somewhat inflated. Per the director, this system will continue to be reviewed and refined to ensure that it accurately reflects staff performance with the implementation of PNMPs. <u>Individual-Specific Monitoring</u> While the type of monitoring described above focused on staff performance, it was tracked per individual rather than per staff, though staff names were a data point. It was not possible, however, to ensure that all staff were monitored for continued and consistent compliance with the current system and likely not realistic to do so. This is different than monitoring that focuses on the individual's health status and the impact of supports and services on health, function, and risk levels, as well as effectiveness. This should be a key element in an effective PNM system and is reviewed in O.7 below.	
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> A system of routine effectiveness monitoring of the PNMPs and dining plans by the professional staff was to be conducted and was outlined in some of the OT/PT assessments reviewed. There was no specific process for this established at MSSLC based on risk, individual factors, or the need for special instructions in the PNMP. The current form did not permit the clinician to review the individual's overall health status to determine if the supports provided were effective in mitigating identified risks. Effectiveness monitoring should address this to determine if the interventions were effective, that the interventions observed should continue to be needed, and that no modifications or additional interventions were needed. Effectiveness should be addressed in addition to compliance monitoring conducted with staff. It was a concern that not all strategies would necessarily be reviewed using the current approach. For example, at the time of the observation, the therapist might observe positioning, but not necessarily transfers. In the current manner, effectiveness of the strategy as implemented is addressed, but effectiveness related to health and/or safety concerns are not. Review of specific health concerns for which the specific strategy was intended to address should also be addressed. These should include any health occurrences since the last review and whether the strategy continued to be the right one. This was done consistently in the annual assessments, but routine review should also occur in the interim. The monitoring forms were not included in the individual's active record, though it was noted that in some cases, the clinicians included an IPN to address this. Not all of these specifically stated that the intervention was effective. There was IPN documentation by therapists related to direct interventions or contacts for	Noncompliance

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		equipment or other troubleshooting, but none routinely done to review all interventions for effectiveness related to the occurrence of health concerns. These reviews should also report on compliance with implementation of plans by staff. Effectiveness monitoring should include programs across all environments and not only in the home.	
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 was a list of individuals who received non-oral intake that identified 26 individuals who received enteral nutrition (8% of the current census). Individual #285 and Individual #314 were listed as having received new tube placements since the previous review. All of the others had been placed just since February 2011. Four individuals were listed with some level of oral intake. Three individuals were listed with poor oral hygiene (Individual #533, Individual #435, and Individual #341), increasing their risk for aspiration pneumonia. Individual #341 was noted below with at least one incidence of pneumonia in the last year. Five individuals with enteral nutrition had been reported with pneumonia in the last 12 months, though the type was not specified on the list provided (Individual #188, Individual #341, Individual #38, Individual #314, and Individual #285). Evaluation of Individuals who Received Enteral Nutrition Ten APENs were requested and six were submitted. • 6 of 6 individuals who received enteral nutrition were evaluated at a minimum annually. • 6 of 6 individuals evaluated had an at least a partial evaluation to determine the medical necessity of the tube, though assessment of oral motor status by the SLP and/or OT did not provide comparative analysis and safety of intake or development of an oral motor treatment plan, as appropriate for any assessment. Some level of oral intake was noted for both Individual #61 and Individual #84. No one admitted to MSSLC since the previous review received non-oral intake, so the following metric did not apply: • ___ of the ___ individuals who received enteral nourishment and were admitted since the last review had a review of the medical necessity of the feeding tube within 30 days. Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition • 6 of 6 individuals who received enteral nutrition had been evaluated by the IDT to determine if a plan to return to oral intake was appropriate, though these were generally incomplete. Most did not clearly reflect assessment by the SLP and/or OT regarding oral motor status with a clear determination of whether the	Noncompliance

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		individual was a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake, but for improved saliva control. Justification for/or against oral motor treatment or potential PO intake should be included as a part of assessment findings. Two of these individuals already received ongoing oral intake. • None of the APENs reflected an adequate assessment by the dietitian regarding current formula and schedule of feedings with a determination if the feeding schedule was the least restrictive or there were potential modifications needed in preparation of transition to oral intake. Plans for individuals identified as potentially benefitting from oral motor intervention or cleared to return to some form of oral intake require a comprehensive plan outlining the treatment or return to PO process. These plans should be: • Integrated into the IHCP, ISP, and/or an ISPA. • Implemented in a timely manner. • Staff responsible for implementation of these oral intake plans trained to competence by a licensed clinician with specialized training in PNM. • Monitored as outlined in the plan. <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. Consideration should be given to individualize follow-up by the PNMT at more frequent intervals as was stated above, in some cases, the IDT had failed to completed specific key actions related to the recommended and agreed upon plan. This was not known until the 30 day follow-up. Further, there were some inconsistencies noted in the documentation by the team that should be tightened up with further review of the assessment elements, consistency and content (O2).

2. A monitoring form that included more discrete measures should be considered so that specific issues could be more readily identified for person-specific and/or systemic change (O6).

3. There was IPN documentation by therapists related to direct interventions or contacts for equipment or other troubleshooting, but none routinely done to review <u>all</u> interventions for effectiveness related to the occurrence of health concerns. These reviews should also report on compliance with implementation of plans by staff. Effectiveness monitoring should include programs across all environments and not only in the home (O7).

4. The new pre-ISP process will identify which team members are required to attend the ISP meeting and the needs for review of the PNMP

should be considered when making this determination (O3).

5. Continue to provide training and support to the IDTs for consistency and timeliness of appropriate referrals to the PNMT (O1, O2).

6. Ensure that evidence of participation by medical providers is clearly documented (O1).

7. Consistently document completion of actions and recommendations to close the loop on identified needs. Streamline system of documentation to ensure ease of use of this valuable information (O2).

8. Review specific measurable exit criteria established in the assessment and include these routinely in PNMT documentation. These should pertain to the reason for referral, but also other issues identified as a function of the comprehensive assessment (O2).

9. The IDTs should utilize referral criteria and other measurable outcomes developed by the PNMT for improved consistency of referral of individuals in a timely manner (O2, O3).

10. Centralize database of key health clinical indicators to ensure it is current and accurate. This should be a facility-wide project that includes key staff. This information should be updated routinely. These may be used by the PNMT to track individuals who meet certain thresholds for health issues that would indicate a need for referral (O2).

11. PNMPs require better integration into the ISP via descriptions of PNM strategies and clear evidence of review of these and their effectiveness relative to risk levels (O3).

12. Consideration for additional refresher courses across more of the core PNM competencies should be considered, particularly in the areas of mealtime and communication. These are areas of support that are provided to every individual living at MSSLC, and as such, staff should be provided more extensive and ongoing training to ensure that competency of performance in these areas is maintained (O5).

13. A system of effectiveness monitoring was not well established and will be necessary for further progress with this provision. Areas, such as toothbrushing and oral sensitivity, should be addressed through assessment, supports and monitoring (O6).

14. Conduct objective reviews of individuals for protective equipment. There are a large number of helmets, gait belts, staff assistance, protective boots, for example. The least restrictive options should be selected. Decisions related to equipment should be data driven (O3).

15. Improve consistency of documentation of transition of individuals from PNMT to the IDT (O2).

16. Address toothbrushing via actual observations in the PNMT evaluations and OT/PT evaluations (O2, O3, and O4).

17. A system to track which staff have been determined to be competent in each level of training should be a coordinated effort by the facility and include CTD, Habilitation Therapy and residential leadership. This is critical to effective staff management to ensure assignment of properly trained staff to individuals for safety and optimal support of specific needs related to care and programming (O5).

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:** Documents Reviewed: o MSSLC client list o Admissions list o Staff list and Curriculum Vitae o Continuing Education documentation o Section P Presentation Book and Self-Assessment o Section O and P QA Reports o OT/PT Tracking o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Completed Compliance 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 ER Visits o Summary Lists 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 Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with Pain 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 With Falls Past 6 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Individuals with Primary Mobility Wheelchairs

	o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted o PNMPs submitted o PNM Maintenance Log o Wheelchair evaluations submitted o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions o OT/PT Assessment Log o New Admissions Spreadsheet o Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to MSSLC**:** Individual #676, Individual #771, Individual #883, Individual #761, and Individual #863 o OT/PT Assessments and ISPs for the following individuals: • Individual #210, Individual #422, Individual #291, Individual #17, Individual #452, Individual #386, Individual #521, Individual #310, Individual #505, Individual #211, Individual #591, Individual #253, Individual #410, Individual #266, Individual #524, Individual #216, Individual #236, Individual #43, Individual #395, Individual #120, Individual #432, Individual #118, Individual #198, Individual #287, Individual #451, Individual #597, Individual #43, Individual #188, Individual #604, Individual #884, Individual #851, Individual #959, Individual #261, Individual #452, and Individual #211. o OT/PT Assessments, ISPs, ISPAs, and other documentation related to OT/PT intervention for the following individuals: • Individual #990, Individual #816, Individual #554, Individual #9, Individual #53, and Individual #243 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 #293, Individual #43, Individual #188, Individual #493, Individual #597, Individual #375, Individual #848, Individual #228, Individual #314, Individual #540, Individual #365, Individual #577, Individual #61, Individual #257, and Individual #143. o PNMP section in Individual Notebooks for the following: • Individual #293, Individual #43, Individual #188, Individual #493, Individual #597, Individual #375, Individual #848, Individual #228, Individual #314, Individual #540, Individual #365, Individual #577, Individual #61, Individual #257, and Individual #143. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #293, Individual #43, Individual #188, Individual #493, Individual #597,

	Individual #375, Individual #848, Individual #228, Individual #314, Individual #540, Individual #365, Individual #577, Individual #61, Individual #257, and Individual #143. Interviews and Meetings Held: o Jessica Barry, MS, CCC-SLP, Director of Habilitation Therapies o Harvey Evans, OTR o Lisa Finley, COTA o Karen Fleming, COTA o Sheila Michael, OTR o Sandra Opersteny, PT o Candy Quieng, PT o Various supervisors and direct support staff o ISP Meeting for Individual #278 Observations Conducted: o Living areas o Dining rooms o Day programs o Work areas
	Facility Self-Assessment: The self-assessment completed by Jessica Barry, Habilitation Therapies Director, was a significant improvement over previous assessments submitted for this section. There were very clear and relevant activities conducted and most linked well to previous reports by the monitoring team. Findings reported were in measurable terms. Ms. Barry reported that due to her short time as director, she had to prioritize the focus of activities and this was reflected in the self-assessment. This was very appropriate because it was necessary to create a new structure for this process rather than build on an existing one. The format used was excellent. Each provision listed the activities to conduct the assessment, results of the self-assessment, a self-rating or analysis and actions taken to demonstrate attempts to move toward compliance were listed for each provision. Ms. Barry was on track to ensure progress is made for the next review. There was a decline in several areas including on-time assessments, comprehensive content, and the quality of OT/PT assessments. Benchmarks (in measurable terms) were not established: this may be an area to consider over the next six months. These benchmarks may be used to establish targets for success and to track progress. The analysis should identify what steps were necessary to resolve problems or address barriers. Though much continued work was needed, the monitoring team acknowledges the strides that Ms. Barry made during the last six months. The facility rated itself as not in compliance with all four items of section P. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings.

	Summary of Monitor's Assessment: There was a decline in the status of substantial compliance in several aspects of provision P. The majority of the assessments, though completed, were completed after the ISP. A late assessment creates a void in the development of an ISP in an integrated team manner. It requires that extra time from all IDT members because a late assessment requires that they meet for an ISPA to ensure that all recommendations are addressed. That is not fair to the individual and to other team members. The content of assessments reflected regression in approximately 33% of these. While there were improvements related to 43% of the elements, only 6% of the assessments reviewed contained over 60% of the required elements. The average for all 16 assessments was approximately 44%. It is critical that clinicians consistently include time spent observing individuals in home, work, and day program areas to identify skill acquisition potentials and environmental changes that could be made. Real time coaching and modeling for staff is key to effective functional implementation. It is essential to step out of the clinical model and infuse energy, knowledge, skills and creativity to enhance and improve active treatment in the homes, day programs and work environments.

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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.	Assessments were submitted for 35 individuals. Of those, 34 of the assessments were current within the last 12 months. The samples of assessments used for review included the following: • Sample P.1 = 3/15 individuals. o No current assessments were submitted from the individual records for Individual #43, Individual #314, Individual #540, and Individual #577. Only assessments contained in the individual records were included for review in this sample. The most current assessments submitted in the individual records for Individual #493, Individual #293, Individual #375, Individual #257, Individual #143, and Individual #228 were identified as updates. Only one of these included the corresponding comprehensive assessment (Individual #228). The facility indicated that per state office, update assessments were considered to be stand-alone documents. This would only be acceptable if all the assessment information was included in the update unless there is reference to the previous assessment. In that case, the previous assessment would need to be available to any reader to ensure availability of all data reported by the clinician. The monitoring team elected to omit review of updates in the absence of the previous comprehensive assessment. o In the case of Individual #98, the most current assessment was a screening due to his readmission and was not included for review below. Assessments of Current Status were submitted for Individual #61 and	Noncompliance

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		Individual #188. There was no evidence of a previous comprehensive assessment in the record for either individual. Current Comprehensive Assessments were submitted for Individual #597 and Individual #365. • Sample P.2 = 13/33 individuals (two were duplicated in Sample P.1: Individual #597 and Individual #188, and three were duplicated submissions in Sample P.2: Individual #211, Individual #452, and Individual #43). The most current assessments submitted for Individual #884, Individual #604, Individual #851, and Individual #959 were screenings and were excluded from this sample for review of Comprehensive Assessments below. Twelve others were Assessments of Current Status and three others were updates, but in the absence of the Comprehensive Assessment were also not included in the sample reviewed below. All others were identified as Comprehensive Assessments. • Sample P.3 = 5/5 individuals newly admitted to MSSLC in the last six months for whom a current assessment was submitted. • P.4 = 6/24 individuals who were provided direct OT and/or PT services per the list submitted. <u>Timeliness of Assessments</u> Forty nine individuals were admitted to MSSLC in the last six months. The New Admissions Spreadsheet included assessments completed for only 22 of these. Seventeen were identified as screenings, two were baseline assessments, and three were listed as comprehensive. The difference between a baseline and comprehensive assessment was not clear. Five OT/PT screenings were submitted for individuals admitted since the previous review. Four of these were included in the spreadsheet. The screening for Individual #676 was not. The screenings were each several pages and appeared to be more of an assessment rather than a screening that would determine if a full evaluation was necessary for an individual. The facility may want to consider developing a strong, but brief screening to rule out a need for assessment for individuals newly admitted rather than this lengthier document. Based on the compliance reported in the spreadsheet submitted: • 18 of 22 individuals admitted since the last review (82%) received an OT/PT screening/assessment within 30 days of admission or readmission per the tracking sheet submitted. All individuals newly admitted during the last six months were not included on this list. Noncompliance was reported for Individual #802, Individual #880, Individual #881, and Individual #990. However, based on the actual dates of admission and submission listed, only one was not completed within 30 days (Individual #802). Additionally, the screening submitted for Individual #676 was also completed within 30 days of admission. The adjusted compliance score would be 22/23 (96%), based on the documentation submitted.	

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		The following metric was not applied due to the inconsistencies noted in the screenings submitted: • If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening (%), received a comprehensive OT/PT assessment within 30 days of identification. Five screenings were submitted. All were of a similar format, very much like the comprehensive assessment format completed for other individuals. Three of the screenings clearly stated that a comprehensive assessment was not needed due to the individual's level of independence with mobility and activities of daily living (Individual #863, Individual #761, and Individual #676). A dining plan was being considered for Individual #676, however, and a re-assessment the following year if adaptive equipment was issued. If a screening indicated a need for services, a comprehensive assessment would be indicated for completion within 30 days of the screening and the need for a dining plan and adaptive equipment should be identified at that time. The clinician did not identify a need for a comprehensive assessment for Individual #771 and Individual #883, yet direct OT services were recommended to explore the use of assistive technology for reading and writing. In these cases, a comprehensive assessment should be completed. Rather it was stated that each would receive a reassessment in three years. OT/PT assessments were submitted as requested : • 3 of 37 individuals' OT/PT assessments (all types) (8%) were dated as completed at least 10 working days prior to the annual ISP. Additionally, there were 97 assessments listed in the tracking log for ISPs dated 1/22/13 through 5/23/13. Based on this log, only 12% of the assessments were performed prior to the designated due date. <u>OT/PT Assessment</u> Only current and complete comprehensive and baseline assessments (16) were included in the following analysis: • 0 of 16 individuals had comprehensive assessments that contained each of the 21 elements outlined below. 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. Based on review of Samples P.1 and P.2 described above, the analysis for comprehensiveness of the OT/PT assessments was as follows: • 13 of 16 individuals' OT/PT assessments (81%) were signed and dated by the clinician upon completion of the written report. Improvement from 0% in the previous review.	

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		• 9 of 16 assessments (56%) included diagnoses and relevance to functional status. This was an improvement from 10% in the previous review. • 3 of 16 assessments (19%) included medical history and relevance to functional status. While the medical history was generally described, there was no reference to the manner in which these impacted functional status. This was an improvement from 5% in the previous review. • 5 of 16 assessments (31%) addressed health status over the last year. Same as the previous review. An improvement from 19% in the previous review. • 12 of 16 assessments (75%) listed medications and potential side effects relevant to functional status. An improvement from 11% in the previous review. • 11 of 16 individuals' OT/PT assessments (69%) included individual preferences, strengths, and needs. An improvement from 43% in the previous review. • 5 of 16 assessments (31%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). Improved from the previous review. An improvement from 0% in the previous review. • 6 of 16 assessments (38%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. This was a decrease from 81% in the previous review. • 4 of 6 assessments provided a 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 also with sufficient rationale (67%). A decrease from 77% in the previous review. • 0 of 16 assessments (0%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. • 2 of 12 assessments (17%) included discussion of the expansion of the individual's current abilities. A decrease from 25% in the previous review. • 1 of 12 assessments (8%) included discussion of the individual's potential to develop new functional skills. A decrease from 14% in the previous review. • 12 of 16 assessments (75%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. This was consistent with the 75% during the previous review. • 2 of 16 assessments (13%) included documentation of how the individual's risk levels impact their performance of functional skills. A decrease from 25% in the previous review. • 10 of 16 assessments (63%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. A decrease from 95% in the previous review. • 0 of 16 assessments (0%) included a monitoring schedule. Same as the previous	

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		review. • 16 of 16 assessments (100%) included a re-assessment schedule. A slight improvement from 95% in the previous review. • 16 of 16 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. Now a required element in all IDT assessments. • 8 of 16 assessments (50%) provided a statement detailed the supports and services needed for successful community living. An improvement from 38% in the previous review. • 14 of 14 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. Same as the previous review. Further findings were as follows: • There were improvements related to 43% of the elements. • There was regression related to 33% of the elements. • Only 6% of the assessments reviewed contained over 60% of the required elements. The average for all 16 assessments was approximately 44%. The current comprehensive assessments generally identified the need for a re-assessment within a specified time frame, though it was not clear if interim updates/assessments of current status were required. The assessments should clearly state the plan for re-assessment, and whether they were comprehensive or updates only. This should be distinguished from the recommended intervals for monitoring for compliance and effectiveness of any supports and services. A number of assessments referred to annual review of supports, such as equipment without mention of additional monitoring for compliance or interim effectiveness monitoring. The monitoring team concurred with the facility in finding this provision to be in noncompliance. Assessments for individuals newly admitted (5/5) were completed within 30 days, though other assessments were consistently late, often well beyond the date of the ISP. Clearly stated content guidelines may be useful to ensure consistency of information included in the assessments. Establishment of clinical competence of the therapists and review of their continued compliance with the elements of the OT/PT assessments may be accomplished via an audit system.	

#	Provision	Assessment of Status	Compliance
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	<u>Direct OT/PT Interventions:</u> The records of individuals in Sample P.4 were reviewed with the following findings: • 4 of 6 individuals' direct intervention plans (67%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. Though a consult was conducted on 7/9/13 per referral for Individual #9 on 7/3/13 and home program exercises were recommended at that time, the plan with staff training to initiate these was not implemented until 8/15/13. A consult for Individual #243 on 3/25/13 indicated a need for direct PT to address an acute injury from a fall on his right shoulder. There was no evidence that this was initiated until 4/23/13. Though this was just within the 30 day period, there was no rationale given as to why there was a delay in initiating this intervention as this was an acute injury with pain. There was no intervention plan and no measurable goals outlined. • For 5 of 6 individuals (83%), the current OT/PT assessment or consult identified the need for OT/PT intervention with rationale. While there was a recommendation for Individual #554 in his OT/PT Evaluation dated 3/7/13, there was no clear rationale why the OT was initiating direct therapy at that time. There was no functional description of his skill performance for fine motor or ADL skills in the assessment. • For 0 of 6 individuals' records (0%), there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. • For 0 of 1 individual's record (0%), whose therapy had been terminated (Individual #243), termination of the intervention was well justified and clearly documented in a timely manner. The system for documentation was not consistent for each of the six individuals reviewed. There was an assessment or consult to identify the need for OT or PT intervention, but the rationale and plan with measurable and functional objectives was not noted in all cases. In some cases, there was an associated SAP/SPO associated with the service. There were no data sheets used, but rather IPNs to document intervention sessions. In the case that the PTA provided the intervention, there was no consistent evidence of review or monthly progress notes completed by the PT. Documentation appeared routine, but did not consistently effectively close the loop on the direct services provided. Review of progress notes should be considered with the following elements: • Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); • A description of the benefit of the program;	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Identification of the consistency of implementation; and • Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. • A comprehensive progress note was completed on at least a monthly basis that offered a comparative analysis to progress made the previous month or across a quarter. • Termination of the intervention was well justified and clearly documented in a timely manner. None of the three individuals were terminated from therapy at the time of this review. Each of these elements was noted for 0 of the 6 (0%) individuals in Sample P.4. <u>Indirect OT/PT Interventions:</u> The primary indirect OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O3 above regarding PNMP format and content. Implementation of PNMPs is addressed in section O5. • For individuals included in the Sample P.1, 13 of 14 PNMPs (93%) were developed/revised within 30 days of the date of the ISP, and/or assessment/update, or sooner as indicated by need. The ISP for Individual #493 was on 9/4/12, but there was no evidence of an update or review of the PNMP until 1/23/13. The PNMP submitted was implemented on 2/11/11 and this appeared to be the only review of his PNMP since that time. Each PNMP should reflect a new date to reflect at least annual review at the time of the ISP. A PNMP was not submitted for Individual #375 with his individual record documents as requested. The facility reported that he had been discharged on 4/9/13, though it was not clear why the PNMP was not available with his other records. • For 7 of 11 individuals (64%) for whom a current OT/PT assessment or update was submitted, the ISPs addressed each of the recommendations for indirect supports outlined in the current OT/PT assessment, including the PNMP. Though recommendations were listed in the ISP when presenting the OT/PT information, these were not consistently listed as services, supports, or actions in the plans. The following exceptions were noted: o Individual #188: There was a recommendation to refer to nursing for oral toothbrushing (Plak-Vac) assessment. Per the IRRF, this was already implemented at the time of the ISP. o Individual #375: A recommendation for referral to the orthotist to replace his insoles due to heel pain was not included in his ISP 8/30/12. o Individual #365: A SAP recommended to manage right knee pain and stabilize his knees secondary to arthritis and lax ligaments was not addressed in the ISP dated 12/18/12.	

#	Provision	Assessment of Status	Compliance
		o Individual #143: It was recommended that the half-finger wheelchair gloves be discontinued and that a trial with Ergo-fit wheelchair hand rims be initiated. These were not addressed in her ISP dated 12/13/12. o Individual #228: The OT/PT assessment suggested discontinuing use of the shoe insoles due to continued good skin integrity. There was no evidence that this was discussed at his ISP on 11/29/12. <u>Integration of OT/PT Supports and Services in the ISP</u> Attendance by either OT or PT or both disciplines was noted for approximately 80% of the ISPs included in Sample P.1. Review of the ISPs submitted was as follows: • 100% (15 of 15) of the ISPs submitted were current within the last 12 months. • 100% (15 of 15) of the current ISPs had attached signature sheets. • 13% (2 of 15) of the current ISPs with signature pages submitted were attended by both the OT and PT. • 33% (5 of 15) were attended by PT only. • 33% (5 of 15) was attended by OT only. • 47% (7 of 15) of the current ISPs had no representation by an OT or PT. The new system of pre-ISPs will designate which disciplines will be required to attend the ISP. The monitoring team looks forward to review of this system during the next review. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment.	
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.5 above. Substantial compliance with O.5 is the standard for compliance with this element. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and	<u>Monitoring</u> A system of monitoring of the PNMPs for staff compliance with the implementation of physical supports and the condition and availability of adaptive equipment was implemented at MSSLC. This was addressed in section O.6 and O.7 above. The previous system of Activity Plans to monitor adaptive equipment had been discontinued. It was not clear how this was going to be accomplished going forward. Many systems will need review and revision by the new department leadership.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	There was limited evidence of effectiveness monitoring by the therapists based on the monitoring sheets submitted. There were a total of 34 sheets completed in April 2013, 19 or 56% were identified as effectiveness monitoring. Of these, some were identified as random competency checks (4), others were listed as individual specific monitoring (10), and still others had no designation at all (5). There did not appear to be a well-defined system as to the frequency that this should occur. Fifteen other forms appeared to be compliance monitoring only. It appeared, based on the PNM maintenance log that monthly maintenance checks were conducted for wheelchairs to ensure that these were in proper working condition. It seemed that these were conducted on a routine basis by wheelchair shop staff, though a referral date was listed. This did not appear to be a referral-based system, but rather scheduled and maintenance check-OK, or the repairs needed were identified in the work requested column. The repairs listed generally were completed on the same day. There did not appear to be maintenance checks for adaptive equipment other than wheelchairs. Other items listed in the log did appear to be referral-based with dates of referral completion dates and work requested listed in the log and also appeared to be completed in a timely manner. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment.	

Recommendations:

1. 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 (P1 and P2).

2. Rationale for therapist attendance in the pre-ISP process needs to be sound and clearly supported (P2).

3. The assessments should clearly state the plan for re-assessment, whether they are comprehensive or updates only. This should be distinguished from the recommended intervals for monitoring for compliance and effectiveness of any supports and services (P2).

4. Timeliness of assessments continued to be a significant issue. Strategies to address this need to be developed (P2).

5. Consider strategies to conduct audits of OT/PT assessments. Clearly stated content guidelines may be useful to ensure consistency of information included in the assessments. Establishment of clinical competence of the therapists and review of their continued compliance with the elements of the OT/PT assessments may be accomplished via an audit system (P1).

6. Review of progress notes should be considered (P2).

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 #74, Individual #455, Individual #92, Individual #600, Individual #176, Individual #350 o Emergency Documentation o Individual #261, Individual #614, Individual #152, Individual #25 Individual #331, Individual #273, Individual #156 o Oral Surgery Consultations o Individual #261, Individual #227, Individual #224, Individual #493, Individual #426, Individual #264, Individual #798, Individual #318 Interviews and Meetings Held: o John Sponenberg, DDS, Dental Director o Jimmy Tompkins, DDS, Staff Dentist o Sandra German, Administrative Assistant o Bennie Kervin, RDA o Christopher Ellis, MD, Medical Director o Angela Johnson, RN, Medical Compliance Nurse

	Observations Conducted: o Dental Clinic o Medical Review Committee Meeting o Desensitization Committee Meeting o Daily Clinical Services 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 self-assessment utilized a standardized template issued by state office. 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. This was the same format used in recent reviews and for the most part, the assessment looked at many areas reviewed by the monitoring team 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. 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 Progress was seen in the provision of dental services. The staff was beginning to understand that having better information could help them to provide better services to the individual. The management of data and information was much improved compared to previous visits. Utilization of this information allowed the dental director to notice trends, call for further review, and implement plans. The facility continued to provide basic dental services onsite, while more advanced services were provided at a local hospital. Many individuals continued to have 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 declined. New initiatives were implemented to help improve this problem. The dental director was assisting CTD in writing SAPs. He also began directly working with direct care professionals on instructing them how to perform suction toothbrushing. Notwithstanding these positive findings, record reviews and documents indicated that home care remained challenging. Individuals came to clinic without have proper hygiene. Getting individual to clinic was in itself at times difficult. Staffing was cited most often as the reason for missed appointments.

	Comprehensive dental assessments were required every six months. Most, but not all, met this timeline. Compliance with the annual requirement was 98%. Maintaining this compliance rate was a significant achievement. Additionally, the quality of the assessments improved as well. Failed appointments decreased to 15%. The dental clinic had implemented a procedure prior to the last visit designed to increase accountability with getting individuals to clinic on time. It appeared to have some value since after notifying supervisors, individuals sometimes appeared in clinic. The desensitization committee, implemented in June 2012, continued to review 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. Eight desensitization plans were developed. It was reported that more individuals were requesting treatment at Scott and White. Consult notes indicated that individuals were requesting to be put to sleep for dental work. The dental director needs to assess the timelines to ensure that sending an increased number of individuals out for treatment does not result in delays in treatment.

#	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, and medical director. The monitoring team also attended several meetings in which the dentist was an active participant. <u>Staffing</u> The dental clinic staff was comprised of a dental director, staff dentist, one registered dental hygienist, two dental assistants, and an administrative assistant. The retirement of a long-term dental hygienist in March 2013 left that position vacant at the time of the compliance review. <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

Dental Clinic Appointments 2012 -2013						
	Oct	Nov	Dec	Jan	Feb	Mar
Preventive	161	133	113	131	93	130
Restorative	40	32	26	45	34	32
Emergency	19	13	14	12	10	3
Extractions	5	0	1	1	0	2
Total Appointments	279	244	210	294	232	272
Off Campus	5	9	18	19	14	18

The overall number of MSSLC clinic appointments decreased, but the number of appointments in the community was increasing. The average number of completed appointments per month was 216 compared to 243 during the last review, though there were a number of holidays during this reporting period. Individuals continued to have comprehensive exams twice a year. The number of appointments for extractions was very low, however, extractions were being done during the off campus appointments.

Emergency Care

Emergency care was available during normal business hours. After business hours, the on-call physician had access to the dental director by phone. Guidance could be provided on treatment and individuals referred to the local emergency department, if necessary.

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. 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. Examples of emergency care are below:

- Individual #261 was seen in clinic on 2/22/13, complaining of a toothache. An examination and x-rays were completed. Decay was noted. The individual requested removal of third molars at Scott and White.
- Individual #152 was seen in clinic on 10/12/12 with a tooth pain. The evaluation showed a missing filling. A temporary filling was placed and the individual received definitive treatment the next month.
- Individual #25 was seen on 2/15/13 complaining of pain from an extraction site. The exam was essentially normal, but the individual was seen again on 2/20/13 and had no complaints.

#	Provision	Assessment of Status	Compliance
		Oral Surgery The documents for 14 individuals referred off campus for treatment were submitted for review. The actual consult was not included for every individual. Several individuals were referred for removal of third molars. Individuals were also referred for full mouth extractions due to rampant decay. One individual had a single extraction. The oral surgeon noted in consults that the individuals were requesting to be put to sleep for the procedures. Individual #224 was seen by a community dentist for a biopsy that was to be completed with IV anesthesia. The oral surgeon requested that the individual receive oral sedation one hour prior to the procedure. He noted "they declined having the ability to give an oral sedative one hour prior to the procedure to make him more comfortable." This was report to be due to the one hour drive to the hospital clinic. During the week of the review, the monitoring team inquired about MSSLC's decision to essentially prohibit the use of oral sedation for dental procedures. It appeared that this was not a policy decision, but was the preference of the providers. The dental director was clearly not in favor of the use of oral sedation or the use of TIVA. Both dentists reported that an increasing number of individuals was requesting dental treatment at Scott and White. They attributed this to individuals seeking off campus trips. They had not considered that the individuals might have made the choice knowing that they would have sedation options off campus. Having treatment off campus is a completely reasonable approach provided the community has the supports to provide treatment in a timely manner and that treatment option is the individual's choice. The dental director did not have any data on the average waiting time for community appointments. Off campus, dental appointments were not scheduled in the dental clinic. This was done by the QDDPs. Oral Hygiene The facility tracked data related to oral hygiene for all individuals. Those data are summarized below. Oral Hygiene Ratings 2012 -2013 | | Oct | Nov | Dec | Jan | Feb | Mar | | Good | 48 | 50 | 38 | 42 | 40 | 46 | | Fair | 47 | 46 | 58 | 50 | 50 | 49 | | Poor | 5 | 3 | 3 | 7 | 7 | 5 | The dental director reported that data entry occurred at the end of each day. While the oral hygiene ratings were declining throughout the facility, tracking oral hygiene in an ongoing manner allowed the dental clinic to notice that one unit had an unfavorable pattern of decreasing good hygiene and increasing poor and fair hygiene ratings. The same unit also had an increase in the "other" category of missed appointments. Further	

#	Provision	Assessment of Status	Compliance
		investigation of this problem revealed that that new dental escort drivers were not entirely clear on the transport process, which increased missed appointments. As a result of this discovery, the clinic began seeing all individuals from the affected unit on one day. Improvement in clinic attendance occurred following the changes. Other steps were taken to further improve the oral health of individuals. SAPs for toothbrushing were developed in the past, but the dental director reported that a new approach was being utilized. The dental director and hygienist were working collaboratively with CTD to develop toothbrushing SAPs which he described as more functional. The clinic staff also participated in training the trainers. One plan was completed and two more were in development. Additional supports included expansion of the suction toothbrushing program. Sixteen individuals now received this treatment. Individuals who received enteral nutrition were the primary recipients. Direct care professionals were trained by a staff LVN to complete the procedure. In recent weeks, this same LVN and the dental director began to jointly monitor the use of suction toothbrushing in the homes. A policy outlining selection criteria, training, treatment, and oversight of this process had not been developed. Notwithstanding these efforts and the emphasis placed on oral hygiene, documentation in the records indicated that individuals continued to come to their appointments with evidence that their teeth were not properly brushed at home. In many instances, the direct care professionals were "floaters" and had no knowledge about the individual's hygiene. <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. This provision remains in noncompliance. The facility needs to continue its efforts to improve oral hygiene and ensure that appropriate care if provided in the homes.	

<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><u>Policies and Procedures</u>
The facility maintained a dental services policy. The dental director reported that the dental policy was changed to reflect after hours emergency procedures. The policies submitted to the monitoring team included no revisions.

<u>Annual/Comprehensive Assessments</u>
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 - 2013</td></tr><tr><td></td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td></tr><tr><td>No. Exams</td><td>37</td><td>54</td><td>46</td><td>67</td><td>64</td><td>66</td></tr><tr><td>Compliant Exams</td><td>37</td><td>54</td><td>45</td><td>66</td><td>64</td><td>66</td></tr><tr><td>% Compliance</td><td>100</td><td>100</td><td>98</td><td>99</td><td>100</td><td>100</td></tr></table>
The overall compliance score was 99%. The comprehensive dental records for six individuals were reviewed. The following is a summary of information found in the most recent comprehensive dental assessment:
• 6 of 6 (100 %) 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
• 6 of 6 (100%) assessments included oral hygiene recommendations
• 6 of 6 (100%) assessments documented the risk rating
• 6 of 6 (100%) 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 progress note. Overall, the documentation for the comprehensive assessments was improved. All of the documents reviewed were complete and the documentation was clear.

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. Management of assessments is discussed</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		further in section H1. Initial Exams The facility submitted data for initial exams done between 10/1/12 and 3/31/13 rather than a list of individuals admitted and status of initial exams. It was reported that 39 of 41 (95%) initial exams were completed within 30 days. Forty-nine individuals were admitted since the last compliance review. The status of the remaining exams was not clear. Dental Records 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. All of the documentation completed in the dental clinic was electronically generated. Overall, the documentation for dental services was greatly improved. The notes were typed and, therefore, legible. The problems with formatting seen in the previous compliance review were resolved. The documentation reviewed was for the most part complete. 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: | | Oct | Nov | Dec | Jan | Feb | Mar | | --- | --- | --- | --- | --- | --- | --- | | Refused | 27 | 11 | 14 | 24 | 10 | 13 | | Missed | 15 | 15 | 12 | 28 | 35 | 27 | | Failed | 42 (15%) | 26 (11%) | 26 (12%) | 52 (18%) | 45 (19%) | 40 (15%) | | Total Scheduled | 279 | 244 | 210 | 294 | 232 | 272 | 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 dental director attended the daily clinical services meeting and provided a report on the prior days clinic including refusals, no shows, etc. The clinic's list of failed appointments included an explanation for each failure. Appointments were missed due to a number of reasons. Other than illness, staffing was the most frequent reason cited for missed appointments followed by home trips and missing active records.	

#	Provision	Assessment of Status	Compliance
		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. Documents showed that several individuals came to clinic following notification of the supervisor. <u>Dental Restraints</u> 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 - 2013 Oct: 0; Nov: 3; Dec: 0; Jan: 3; Feb: 6; Mar: 6 General Anesthesia/Sedation Pretreatment sedation was not utilized at MSSLC. All individuals who were going off campus for any procedure that required sedation were discussed at the Medical Review Committee meeting. The discussion was not focused on pretreatment sedation, but on the supports that would be required before and after the off-campus sedation. <u>Strategies to Overcome Barriers to Dental Treatment</u> The clinic failure rate for the reporting period was 15%. This was a decrease from the failure rate of 20% seen during the last compliance review. 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 facility continued to have monthly meetings of the desensitization committee. The committee met to discuss every individual who refused dental treatment or exhibited difficult behaviors in clinic. Following discussion, a disposition was made which was usually referral to the team along with some recommendations. The committee also reviewed medication refusals, and received reports on a number of other issues. During the meeting attended by the monitoring team, individuals with dental issues were presented by the dental director. The committee then explored potential causes and made a decision regarding team referral. For Individual #369, who had weekly visits to the dental clinic, the dental director requested that habilitation services conduct an assessment because of the behavior, which he thought was due to tactile defenses.	

#	Provision	Assessment of Status	Compliance
		There were eight desensitization plans in place. The dental director reported that all individuals who were identified to need a formal desensitization plan had one in place. The plans reviewed were individualized and appeared to address the appropriate barriers. Overall, it appeared that this process was effective in bringing together the appropriate disciplines to discuss barriers to dental treatment and how those barriers could be removed. A full spectrum of treatment options was noted ranging from utilization of a preferred staff person to development of SAPs and desensitization plans. This provision remains in noncompliance. The facility needs to address the problem of failed dental appointments.	

Recommendations:

1. The dental director should continue to recruit a replacement for the open hygienist position (Q1).
2. The dental director should try to determine why the number of individuals requesting treatment off campus continues to increase (Q1).
3. The dental director should continue to provide support to CTD in developing toothbrushing SAPs. The effectiveness of these interventions should be monitored (Q1)
4. The suction toothbrushing procedure should be codified in policy and procedure (Q1)
5. 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).
6. Policies and procedures should be updated to reflect current practices (Q2).
7. The state dental services coordinator should develop tools to determine the quality of the dental assessments completed at the facility (Q2).
8. The Desensitization Committee should continue its review of individuals who refuse treatment and ensure adequate follow-up (Q2).
9. The facility must address the problem of missed appointments due to staffing, transportation, unknown appointments, etc. (Q2).

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Admissions List o Budgeted, Filled and Unfilled Positions list, Section I o Section R Presentation Book o Facility Self-Assessment, Action Plans and Provision of Information o Current SLPs (including contract staff), license numbers, caseloads and ratios o Continuing education and training completed by the SLPs since the last review o Facility list of new admissions since the last review o Tracking log of SLP assessments completed since the last review o SLP/Communication assessment template o Speech Language Pathology Screening template o List of individuals with behavioral issues and coexisting severe language deficits o List of individuals with PBSPs and replacement behaviors related to communication o PBSP minutes and attendance rosters for the past six months o List of individuals with Alternative and Augmentative communication (AAC) devices o AAC-related database reports/spreadsheets o List of individuals receiving direct communication-related intervention plans o Communication monitoring forms submitted o Summary reports or analyses of monitoring results o Communication Assessment for individuals recently admitted to MSSLC: Individual #863, Individual #761, Individual #883, Individual #771, Individual #604, and Individual #253. o Communication Assessments and ISPs for the following individuals: o Individual #410, Individual #505, Individual #310, Individual #10, Individual #604, Individual #17, Individual #341, Individual #524, Individual #591, Individual #386, Individual #362, Individual #452, Individual #266, Individual #210, and Individual #216. o Communication Assessments, ISPs, ISPAs, SAPs and other documentation related to communication for the following individuals: Individual #45, Individual #580, Individual #455, Individual #123, Individual #321, Individual #503, Individual #285, Individual #567, Individual #185, and Individual #175. 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: o Individual #293, Individual #43, Individual #188, Individual #493, Individual #597,

	Individual #375, Individual #848, Individual #228, Individual #314, Individual #540, Individual #365, Individual #577, Individual #61, Individual #257, and Individual #143. o PNMP section in Individual Notebooks for the following: o Individual #293, Individual #43, Individual #188, Individual #493, Individual #597, Individual #375, Individual #848, Individual #228, Individual #314, Individual #540, Individual #365, Individual #577, Individual #61, Individual #257, and Individual #143. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: o Individual #293, Individual #43, Individual #188, Individual #493, Individual #597, Individual #375, Individual #848, Individual #228, Individual #314, Individual #540, Individual #365, Individual #577, Individual #61, Individual #257, and Individual #143. <u>Interviews and Meetings Held</u>: o Jessica Barry, MS, CCC-SLP, Director of Habilitation Therapies o Various supervisors and direct support staff o ISP Meeting for Individual #278 <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas
	Facility Self-Assessment: The self-assessment completed by Jessica Barry, Habilitation Therapies Director, was a significant improvement over previous assessments submitted for this section. There were very clear and relevant activities conducted and most linked well to previous reports by the monitoring team. Findings reported were in measureable terms. Ms. Barry reported that, due to her short time as director, she had to prioritize the focus of activities and this was reflected in the self-assessment. This was very appropriate because it was necessary to create a new structure for this process rather than build on an existing one. The format used was excellent. Each provision listed the activities to conduct the assessment, results of the self-assessment, a self-rating or analysis, and actions taken to demonstrate attempts to move to compliance. Ms. Barry was on track to ensure progress is made for the next review. There was a decline in several areas, including on-time assessments, comprehensive content and quality of communication assessments, and the provision of AAC. Benchmarks (in measurable terms) were not established; this may be an area to consider for future assessment over the next six months. These benchmarks may be used to establish targets for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the strides that Ms. Barry made during the last six months. The facility rated itself as not in compliance with all four items of section

	R. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings.
	Summary of Monitor's Assessment: There was a decline in the status of substantial compliance in several aspects of provision R. The majority of the assessments, though completed, were completed after the ISP. A late assessment creates a void in the development of an ISP in an integrated team manner. It requires that extra time from all IDT members because a late assessment requires that they meet for an ISPA to ensure that all recommendations are addressed. That is not fair to the individual and to other team members. The content aspect of assessments reflected regression in many elements and the majority of the assessments (80%) contained less than 50% of the key elements. It is critical that clinicians include time spent observing individuals in home, work, and day program areas to identify skill acquisition potentials and environmental changes that could be made. Real time coaching and modeling for staff is key to effective functional implementation. There was no increase in the provision of AAC systems. Therapists should be observing the position and set up of activities in these areas to improve alignment and support, increase productivity and promote new skill acquisition. More clinical knowledge related to the application of AAC to adults with developmental disabilities and physical and cognitive challenges was needed. The clinicians did not appear to have significant experience in the provision of AAC. Much work was needed, but with the leadership demonstrated by Ms. Barry, the monitoring team is confident that progress will be evident during the next review. <u>The following samples were used by the monitoring team:</u> • Sample R.1: Individuals included in the sample selected by the monitoring team. • Sample R.2: Individuals with assessments submitted by MSSLC as most current. • Sample R.3: Individuals admitted since the last compliance review. • Sample R.4: Individuals receiving direct speech services • Sample R.5: Individuals from Sample R.1 with indirect communication supports (e.g., skill acquisition plans not directly provided by the SLP/SLPA, Communication Dictionaries).

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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	<u>Staffing</u> Karen Davila, MA, CCC/SLP, Vanessa Sabir, and David Ehrenfeld, MSEd, CCC/SLP, were identified as SLPs and Gay Maynard, AuD, CCC-A was identified as an audiologist per the Department Roster. Each provided communication services. There were five positions budgeted, though only two were listed as filled as of 4/30/13. There were three part-time contractors listed (including Sheri Morytko, Andrea Curl and Jessica Barry). There were no SLP Assistants employed at the time of this review.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Jessica Barry had previously served only on the PNMT (since 9/17/12) and then was appointed as the Interim Director of Habilitation Therapies. She was recently named as the Director on 4/16/13. The self-assessment indicated that there were five SLP positions and all were filled as of 4/30/13 (three were listed as state positions and two were listed as contract). There were two state positions for SLPAs and none were filled per the self-assessment. One contractor was recently released and the contract for another ended as of 5/31/13, so Ms. Barry was also covering her caseload in the Martin unit, in addition to her duties as director and as a member of the PNMT. Ms. Sabir began on 5/28/13. Responsibilities of the SLPs included, but were not limited to conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs related to communication. The same duties were required for the provision of mealtime supports for these individuals as well. The SLPs were assigned caseloads as follows (totals based on individual list by home): • David Ehrenfeld: Barnett and Whiterock: approximately 140 individuals (8% with severe language deficits) • Karen Davila: Longhorn and Shamrock: approximately 103 individuals (only one individual listed with a severe language deficit) • Vanessa Sabir and Jessica Barry: Martin: 92 individuals (51% with severe or profound language deficits) The clinicians were assigned responsibilities for both communication and mealtimes and, as such, the caseload assignments were significantly high. This may impact the ability of the speech clinicians to appropriately provide adequate supports and services in each area as noted below. A system had been developed by the current director to track recruitment efforts, contract availability, and responses from vendors. <u>Qualifications:</u> • 5 of 5 SLPs (100%) were licensed to practice in Texas as verified online. <u>Continuing Education:</u> Based on a review of continuing education completed in the last 12 months: • 1 of 5 SLPs (20%) had completed continuing education related to communication and relevant to the population served. The continuing education topic likely relevant to communication included: • Issues in Evaluation and Treatment of Individuals with Developmental	

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		Disabilities (Davila) Numerous others were listed in the self-assessment on page 145-146, though many did not directly pertain to communication services. The person who attended, number of contact hours or CEUs, and dates of participation were not listed. The self-assessment indicated that 80% of the clinicians had attended the 20 courses listed. A number of these pertained to PNM services, and some were in-house inservice training required by the state, however, and only two appeared related to communication. While the extent of continuing education listed was very commendable, this provision pertained to communication and only courses relevant to communication were considered here. Only one of those communication-related courses listed the clinician who attended. The intent of ongoing continuing education was to ensure that the clinicians attained and/or maintained knowledge and expertise related to the provision of communication supports and services, particularly related to AAC. A system to track participation in continuing education was in place per the self-assessment. More knowledge and experience was needed in order to increase their understanding of AAC use with adults with developmental disabilities and physical and cognitive challenges. They appeared to rule out AAC as an option based on an individual's cognition or results from previous assessments. There was little evidence that actual assessment of AAC was conducted in most of the current comprehensive assessments. The clinicians did not appear to recognize the role of relevance, alternate access sites, environmental context, and meaningful contextual training opportunities as effective methods in the development of AAC for this population. <u>Facility Policy:</u> There was no local policy related to communication. The local policy should provide clear operationalized guidelines for the delivery of communication supports and services, including the following components: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.). • Outlines assessment/update schedule including frequency and timelines for completion of new admission assessments (within 30 days of admission or readmission), timelines for completion of comprehensive assessments (within 30 days of identification via screening, if implemented), and timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within 5 days of identification as indicated by the IDT). • Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment. • Addressed a process for effectiveness monitoring by the SLP.	

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		• 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.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	<u>Assessment Plan:</u> There was no Master Plan submitted, though a notation was provided stating that there had been no changes made to the plan. During the previous review, a 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. In general, it appeared that the assessments had been completed per the ISP dates rather than prioritized by need. There was still no evidence of who required a communication assessment or the completion dates for all communication assessments completed for individuals living at MSSLC. The self-assessment indicated that between 1/1/13 and 4/30/13, 100% of individuals were screened/assessed per policy and that 100% of individuals had received a comprehensive assessment per the Master Plan. This could not be validated by the monitoring team because though requested, it was not submitted. On time submission of these (10 working days prior to the ISP) was not included in the self-assessment. The tracking log listed 63 assessments as completed in the last six months. The spreadsheet listed the ISP date, the date the evaluation was submitted (signed and dated), and the date of the assessment. Nineteen of these were completed after the ISP was held. Six were submitted on the date of the ISP. There were 38 submitted prior to the ISP, but only 18 were submitted 10 working days before. As such, only 29% were on time. These included both comprehensive and update assessments. This delay significantly impacts the ISP process because the necessary information is not available for appropriate discussion and decision-making. It could not be readily determined if an ISPA was conducted upon completion of each of these delinquent assessments in order that the findings and recommendations could be integrated into the plan. None of the existing communication assessments had been audited to determine if they met the current state-established format and content guidelines. <u>Assessments Provided</u> Communication assessments were submitted as requested for the following: • Sample R.1: 11/15 individuals (no assessments were submitted for Individual #375 who was reported to have been discharged, Individual #365, Individual #540, and Individual #257 who was reported to not have communication	Noncompliance

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		needs). Assessments for Individual #228 and Individual #493 (who did not have communication needs) were not current within the last 12 months and, as such, were not included in this review. Several assessments were submitted for Individual #228 (7/12/10, 12/12/11, and one other that was incomplete). Nine assessments were considered to be current as follows: o Comprehensive Assessment ▪ Individual #597 (2/20/13) o Baseline Assessment ▪ Individual #98 (3/4/13) o Baseline Update Assessment ▪ Individual #577 (9/4/12) ▪ Individual #293 (10/11/12) ▪ Individual #314 (10/4/12) o Update Assessment ▪ Individual #43 (3/14/13) ▪ Individual #143 (11/13/12) o Assessment of Current Status ▪ Individual #188 (3/29/13) ▪ Individual #61 (4/23/13) • Sample R.2: 15 individuals assessments completed by three clinicians. All 15 assessments were considered to be current as follows: o Comprehensive Assessment ▪ Individual #505 (4/11/13) ▪ Individual #310 (2/11/13) ▪ Individual #410 (2/5/13) ▪ Individual #524 (1/22/13) ▪ Individual #261 (2/25/13) ▪ Individual #17 (1/31/13) ▪ Individual #591 (1/31/13) ▪ Individual #386 (2/27/13) ▪ Individual #216 (4/3/13) ▪ Individual #452 (3/6/13) ▪ Individual #266 (3/18/13) • Baseline Update Assessment 12. Individual #341 (3/18/13) • Update Assessment 13. Individual #210 (2/25/13) • Assessment of Current Status 14. Individual #188 (3/29/13) • Speech Language Pathology Screen	

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		15. Individual #604 (2/28/13) Thus, 26 of 30 individuals in Samples R.1 and R.2 (87%) were provided a current communication assessment. It was not possible to determine if the other individuals were scheduled to receive an assessment because the Master Plan was not submitted. As described above, a number of the assessments submitted were updates or assessments of current status that referenced either a previous comprehensive or baseline assessment. These updates to the original assessments should not be considered a complete assessment in the absence of the original assessment. Not all information from those original assessments was included in the updates and, therefore, should remain available for reference in the active record. This was considered for those submitted for Sample R.1. No comprehensive or baseline assessments were contained in the record for Individual #188, Individual #61, Individual #43, Individual #314, or Individual #143. In the case of Individual #577, the baseline assessment was included (10/26/10). It identified that an update was due in 2011, though there was no evidence of this in his record. In the case of Individual #228 there was an incomplete baseline (7/12/10), an update (12/12/11), and an additional update with no identifiable date. Only in the case of Individual #293 was the baseline (10/28/10) and each of the subsequent updates (11/17/11 and 10/11/12) included in his record. There were 49 individuals admitted to MSSLC in the last six months. Five assessments for individuals newly admitted were submitted and included in Sample R.3. All but one was included in the tracking log (Individual #253). • 4 of 5 individuals admitted since the last review (80%) received a communication assessment within 30 days of admission, based on assessments submitted. The assessment for Individual #253 was dated 4/1/13. It could not be determined if it was submitted within 30 days of his admission. A screening was to be provided for individuals with a change in status, per the facility policy, however, there was no evidence that this occurred during this review period: • 0 of 0 individuals identified with therapy needs through a screening (%), received a comprehensive communication assessment within 30 days of identification. Only one screening was submitted (Individual #604). This was completed for his admission. No assessment was indicated • 3 of 4 individuals (75%) in the sample of individuals who were provided direct communication supports and services (Sample R.5) were provided an assessment current within the last 12 months. Individual #580 was listed with direct speech services, but his most current assessment was dated 3/26/12.	

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		Communication Assessment: Based on review of the sample of comprehensive assessments (including one identified as a Baseline Assessment for Individual #98) completed since the previous review included in Samples R.1 and R.2, it was noted that none of the 10 individuals had comprehensive assessments that contained all of the 24 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. The comprehensiveness of the communication assessments were as follows: • 9 of 10 individuals' communication assessments (90%) were signed and dated by the clinician upon completion of the written report. • 0 of 10 individuals' communication assessments (0%) were dated as completed at least 10 working days prior to the annual ISP. This was a decrease from 88%. • 3 of 10 individuals' communication assessments (30%) included diagnoses and relevance of impact on communication. This was an improvement from 0%. Most listed the diagnoses only. • 9 of 10 individuals' communication assessments (90%) included individual preferences, strengths. This was an improvement from 0%. Though these were listed in each assessment, they were rarely used to guide the development of meaningful communication strategies or AAC systems. • 0 of 10 individuals' communication assessments (0%) included medical history and relevance to communication. This was consistent with the previous review. Some listed medical history, but none identified the impact on communication. • 7 of 10 individuals' communication assessments (70%) listed medications and discussed side effects relevant to communication. This was an improvement from 3%. • 1 of 10 individuals' communication assessments (10%) provided documentation of how the individual's communication abilities impacted his/her risk levels. This was an improvement from 0%. • 4 of 10 individuals' communication assessments (40%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. This was a decrease from 55%. • 0 of 10 individuals' communication assessments (0%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was a decrease from 12%. • 3 of 3 individuals' communication assessments (100%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as	

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		the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally. The dictionary was recommended, but most assessments did not discuss whether it required modifications. Many individuals in the sample were verbal and did not require a communication dictionary. This was an improvement from 0%. • 1 of 8 individuals' communication assessments (13%) included discussion of the expansion of the individuals' current abilities. This was a decrease from 21%. • 1 of 9 individuals' communication assessments (11%) provided a discussion of the individuals' potential to develop new communication skills. This was an improvement from 9%. • 2 of 4 individuals' communication assessments (50%) included the effectiveness of current supports, including monitoring findings. This was an increase from 0%. • 0 of the 4 individuals' communication assessments (0%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC. This continued to be an area that needed improvement, and was a decrease from 27%. The rationale for not providing AAC was often weak. For example, in the case of Individual #310, it was reported that he did not indicate cause and effect, or tolerate targeted tasks for longer than a few seconds. There did not appear to be any effort to evaluate for this due to reported prior lack of success In the case of Individual #524, she was not considered a candidate for AAC assessment due to reported lack of responsiveness, ability for cause and effect, and symbol representation in the past. There was no evidence of a current assessment. Each of these individuals, however, demonstrated apparent case/effect awareness. For example, Individual #524 stated "Don't," "Shut Up," and "Stop" when in pain or did not want to be touched. There is no need to understand or identify symbols/pictures to benefit from AAC. Individual #310 was reported to pull on staff if he wanted something or needed help. His PNMP made reference to a communication book. • 0 of 9 individuals' communication assessments (0%) offered a comparative analysis of health and functional status from the previous year. This was consistent with the previous review. • 6 of 10 individuals' communication assessments (60%) gave a comparative analysis of current communication function with previous assessments. This was an improvement from 45%. • 7 of 10 individuals' communication assessments (70%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was a slight decrease from 79%. • 8 of 10 individuals' communication assessment (80%) had specific and	

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		individualized strategies outlined to ensure consistency of implementation among various staff. • 10 of 10 individuals' communication assessments (100%) had a reassessment schedule. This was an improvement from 91%. • 1 of the 5 individuals' communication assessments (20%) supplied a monitoring schedule. This was an improvement from 0%. • 1 of 5 individuals' communication assessments (20%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. This was an improvement from 12%. • 10 of 10 individuals' communication assessments (100%) made a recommendation about the appropriateness for community transition. • 3 of 10 individuals' communication assessments (30%) included specific recommendations for services and supports in the community. This was an improvement from 0%. • 3 of the 10 individuals' communication assessments (30%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was a decrease from 82%. Additional findings related to the communication assessments were as follows: • 0 of 10 assessments contained more than 70% of the elements listed above. • 1 of 10 assessments contained 60% to 69% of the elements listed above. • 1 of 10 assessments contained 50% to 59% of the elements listed above. • 4 of 10 assessments contained 40% to 49% of the elements listed above. • 4 of 10 assessments contained 30% to 39% of the elements listed above. • 3 of 24 (13%) of the elements listed above were noted for 100% of the assessments reviewed. There were no content guidelines used by the clinicians to ensure that the required content was addressed in each assessment. There was no system of assessment audits implemented by the department for the establishment of competency of the speech clinicians and to ensure continued compliance with the assessment guidelines. <u>SLP and Psychology Collaboration:</u> There were approximately 282 individuals listed with PBSPs and 16 of these were included in the Samples R.1 and R.2 identified above. • 15 of 15 communication assessments reviewed for individuals in Sample R.2 (100%) addressed some aspect of the individual's behavior in the Behavioral Considerations section. Six of these individuals were identified as provided a PBSP. This section reported behaviors observed by the SLP during assessment	

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		and stated the target and replacement behaviors per the PBSP. None of these discussed any communicative intent of these behaviors. In the case of Individual #310, the SLP reported that the PBSP identified use of sign language as a replacement behavior. It was further reported that staff indicated that he did not use signs. There was no analysis provided by the SLP as to whether sign language use was appropriate and there was no evidence that there was a plan to collaborate with psychology regarding this issue. A section related to the impact of behavior on services and supports was included in the assessment. The clinicians typically merely stated that if they engaged in challenging behaviors they did not benefit from their services or that they would be less likely to transition to the community. • For 7 of 13 individuals (54%) in Sample R.2 for whom current ISPs were submitted, communication strategies identified in the assessment were included in the ISP. There were strategies identified in the ISP for Individual #310, but they were not consistent with the communication assessment. In some cases (Individual #452, Individual #143, and Individual #266) the information documented in the ISP related to communication was more specific than the assessment. For those individuals included in Sample R.1, there were current ISPs submitted for each. PBSPs were included in the individual records as submitted for nine individuals. Current communication assessments were submitted for nine individuals. For individuals in Sample R.1 for whom current PBSPs, ISPs, and communication assessments were requested and received (Individual #293, Individual #597, Individual #98, and Individual #314) the following was noted: • For 2 of 4 individuals (50%), communication strategies identified in the assessment were at least partially included in the PBSP (Individual #597 and Individual #98), though those in the PBSP for Individual #98 were not entirely consistent with the communication assessment. • For 0 of 7 individuals (0%) communication strategies identified in the assessment were included in the ISP. Communication strategies were listed for Individual #577, but they were not the same ones listed in his assessment. In the cases of Individual #61 and Individual #188, there were no strategies identified in the communication assessment. Though collaboration with psychology was reported, there was no evidence of this in the documentation submitted. Participation in the development and review of PBSPs was an opportunity to promote collaboration between psychology and the SLPs for assessment and program development.	

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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 ISPs for 17 individuals in Sample R.1 the following was noted: • 15 of 15 ISPs (100%) were current within the last 12 months. • In 8 of 15 ISPs reviewed (53%), there was evidence that a SLP attended the annual meeting. At least 14 of these individuals had significant communication deficits. No pre-ISP information was submitted to determine who was required to be at any upcoming ISPs. • In 8 of 11 ISPs for individuals with communication supports (73%), the type of AAC and/or other communication supports (e.g., Communication Dictionary, Communication Plan, and strategies for staff use) were clearly identified. In some cases, only one support was mentioned (Individual #143), or not mentioned at all (Individual #577, Individual #188, and Individual #228) • Of the Communication Dictionaries provided to 9 of 15 individuals (60%), only three were reviewed at least annually by the IDT, as evidenced in the ISP. The only ISP that clearly stated this, however, was for Individual #314. The other two documented IDT approval of continued use, but did not address the accuracy of the content or necessary changes. • 11 of 15 ISPs (73%) included a description of how the individual communicated. Four descriptions stated merely that the individual was verbal and only one of these listed strategies for staff use. • 7 of 15 ISPs (47%) contained skill acquisition programs to promote communication. Only one of these involved participation related to program development by the SLP (Individual #188). The functionality of a number of these other programs was questionable. All of these would benefit from collaboration with the SLP to develop appropriate and meaningful learning objectives, steps, and strategies: o Individual #43 was to improve his communication skills by independently responding when spoken to. o Individual #257 was to state her birthdate. o Individual #143 was to turn on a radio with a switch and hold it down to continue to listen to the music. This was not practical and not functional as no one else has to hold a button down in order to listen to the radio. A timing device should be used to automatically turn the radio off after a prescribed length of time, so she would be required to reactivate the switch to turn it back on. o Individual #293 was to touch his nose. o Individual #540's ISP mentioned a need for him to learn signs, but there was no SAP listed for implementation. There was no evidence of a communication assessment. • In 0 of 15 ISPs reviewed (0%) information regarding the individual's progress	Noncompliance

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		on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP were included. <u>Individual-Specific AAC Systems:</u> There were only 12 individuals who were provided some type of AAC: Big Step by Step (2), Step by Step (1), Communication Wallet (5), flashcards (1), Big Talk Triple Play (3), Big Mack switches (2), Powerlink with switch (1), and a Go Talk 4 (1). During the last review, it was reported that 21 individuals were provided AAC. This appeared to be a decrease in the provision of AAC for individuals living at MSSLC. Individuals who used sign language were not included in the current list. During the previous review, it was reported that 109 individuals had Communication Dictionaries and two had environmental control devices. It was not known how many individuals were currently provided these supports. There was no evidence of Communication Plans. In some cases, AAC was dismissed based on a previous assessment, rather than a new one. Cognition was used frequently as a rationale to rule out AAC use, which is not in line with to current practice. There were no plans to provide SAPs or other supports to promote skill acquisition related to AAC. In most cases, the responsibility was placed on the home or day program staff with no evidence of supports from the therapists beyond quarterly monitoring. Also, the speech clinicians appeared to consider only the hands as the primary means to activate a switch, whereas a number of individuals might have been able to gain access in alternate ways. Collaboration with OTs and PTs may be helpful in the identification of these alternatives. Most of the assessments for the individuals in Sample R.1 did not consistently provide an adequate assessment of the individuals' potential for AAC use through direct intervention and trials occurring in the natural environment in situations that were most meaningful to the individual. There was no evidence of the use of training/teaching models to expose and promote interest and use of AAC across settings. There did not appear to be any attempts made for use in a setting over time that would spark interest, such as to request a favorite item, food, beverage, music, vibration or massage. <u>General Use AAC Devices:</u> Though general use devices were noted in some areas, these were not quantified in the documentation submitted. <u>Direct Communication Interventions:</u> There were 15 individuals listed as participating in direct communication-related interventions provided by the SLP. Most of these pertained to fluency, articulation, and language skills. This was a notable improvement from the previous review when only two were reported to receive direct communication therapy.	

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		Generally accepted practice standards for comprehensive progress notes related to communication interventions include: • Contained information regarding whether the individual showed progress with the stated goal. • Described the benefit of device and/or goal to the individual. • Reported the consistency of implementation. • Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. Records related to the provision of direct intervention plans for five individuals were reviewed (Sample R.4). This included assessments, ISPs, ISPAs, SAPs and progress notes. Findings were as follows: • Individual #580**:** His most current assessment was 3/26/12 and direct speech therapy was recommended to improve intelligibility. There was no evidence that this had been provided. Per his current ISP dated 3/12/13, he was to participate in therapy two times per week following an initial consult. It was not clear why a current assessment update had not been provided to establish the rationale for intervention. A Speech Therapy Skilled Objective Plan had an implementation date of 3/26/13. There were notations for eight sessions through 5/25/13. Short term goals were established related to correct speech production. Frequency was listed as one to two times weekly with no established duration. He was seen only one time each week, though his ISP indicated that it would be twice weekly. • Individual #123**:** His most current communication assessment was dated 12/18/12. It was recommended that he participate in direct speech therapy to address articulation for 30 minutes one time a week for an indefinite period of time. A speech therapist did not attend his ISP on 1/15/13 and there was no evidence of this recommendation in the plan. Therapy sessions were not provided weekly and the progress notes did not meet basic generally accepted standards for documentation of direct intervention. There were no established goals and the elements listed above were not included in any of the notes. • Individual #455: His most current communication assessment was dated 12/19/12 and indicated that he might benefit from direct speech therapy, but there was no rationale offered and the focus of this need was not stated. His ISP dated 1/16/13 stated that the program plan for language stimulation would be discontinued, but there was no evidence that the recommendation for direct therapy was addressed by the IDT, though the SLP attended the meeting. A plan was implemented on 1/16/13 to facilitate improved speech production and functional utterances. Specific measurable objectives were outlined with a	

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		frequency of one to two times weekly for an unspecified duration. He was seen for 15 sessions from 1/24/13 through 5/2/13. He was generally seen weekly and the progress notes generally included the elements outlined above. • Individual #45**:** His assessment was dated 8/17/12. It was recommended at that time that he participate in direct speech therapy two times a month to improve oral expression and intelligibility. Though mentioned in the ISP dated 9/12/12, it was not included as a specific goal or outcome. There were 16 entries related to therapy sessions from 10/2/12 through 5/23/13. A SAP was initiated on 9/25/13 for therapy two times weekly. There were specific goals stated, but these were not in measurable terms. IPNs were very poorly written and did not meet any of the generally accepted elements listed above. The therapist made statements including, "Good work in speech. Improving sounds and vocabulary." There were no data provided in any of the notes and no rationale for continuing therapy and specific progress toward the goals. • Individual #188: Her most current assessment was dated 3/29/13. Skilled therapy was deemed unwarranted at that time. The PNMT SLP had identified a need for direct therapy to address her alertness and to increase her response to a variety of stimuli via a consult on 3/15/13, establishing the rationale for direct intervention. This was implemented on 4/9/13 and the IDT agreed that it should continue. A plan was implemented on 4/8/13. There were very specific goals stated in measurable terms with frequency established at three to five times weekly for four weeks. There were entries for 11 sessions with the SLP from 4/9/13 through 5/3/13. She was generally seen three times per week. Notations were very specific and data-based, clearly linked to the objectives of the intervention. All essential elements were present in the documentation of this intervention.. There was inconsistency in the documentation and provision of direct intervention related to communication. Guidelines for the development of plans and documentation are needed with staff training for appropriate implementation. Routine review and audits of these is indicated. <u>Indirect Communication Supports:</u> Indirect communication supports for individuals in Sample R.5 included the communication dictionary only. The dictionaries were inconsistently described in the ISPs. There was no evidence of consistent documentation for the individuals in this sample, related to the benefit and effectiveness of the supports, consistency of implementation, or recommendations related to necessary changes. In most cases, the clinician merely stated that the dictionary was reviewed for use and condition. • Individual #257: His communication dictionary was monitored one time on	

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		5/14/12. It was stated that it needed to be reviewed and updated. There was no evidence that this had been done. • Individual #577: His communication dictionary was monitored one time on 12/6/12 since 10/6/11. It was stated only that it was in good condition. Effectiveness or accuracy was not addressed. • Individual #597: There was no evidence of monitoring since 1/9/13 and on 4/9/13, it was stated that the system of monitoring was discontinued. • Individual #314: There was no evidence of monitoring since 10/4/12 and on 4/9/13, it was stated that the system of monitoring was discontinued. • Individual #540: There was no evidence of monitoring since 3/14/12, and on 4/9/13, it was stated that the system of monitoring was discontinued. • Individual #43: There was no evidence of monitoring since 4/13/12, and on 4/9/13, it was stated that the system of monitoring was discontinued. <u>Competency-Based Training and Performance Check-offs:</u> New employees participated in NEO classroom training and completed competency check-offs for foundational skills related to communication. Per the schedule, the combined classes for deaf awareness, pragmatics, verbal and nonverbal communication, and AAC were only two hours. All aspects of communication training, including the competency check-offs provided to new employees should be a key part of NEO. A system to track which staff have been determined to be competent in each level of training should be a coordinated effort by the facility and include CTD, Habilitation Therapy, and residential leadership. This is critical to effective staff management to ensure assignment of properly trained staff to individuals for safety and optimal support of specific needs related to care and programming. NEO training was provided by a licensed SLP. There did not appear to be a system to audit the training to review for content, consistency of presentation and competency check-offs. No refresher training was completed in the area of communication. This was of significant concern to the monitoring team. This is an area that impacts all individuals who live at MSSLC and staff effectiveness is dependent on successful communication with individuals as well as them accurately interpreting and responding to individual efforts to communicate with staff and others. More time to address this critical area is needed for NEO, and communication should be addressed annually through refresher training.	

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R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	Monitoring System: A system of monitoring was established at MSSLC using a universal monitoring form rather than one specifically related to communication. As such, it was not possible to discern discrete measures such as the following: • Type of equipment or support monitored • Communication equipment was present • Equipment was found in the correct location • Equipment was in working condition • Staff response to use of the device • Staff were able to describe the purpose of the device. • Tracking of the effectiveness monitoring of AAC systems that was conducted by the speech therapists or the IDT with documentation in the IPN or ISP. There was no local speech services policy for monitoring of communication supports to address: • Monitoring for the presence of communication adaptive equipment or other AAC supports/materials. • Monitoring for the working condition of communication adaptive equipment. • The frequency of monitoring. • Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work). • The process for identification, training, and validation for monitors. • The process of inter-rater reliability. • A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). The self-assessment reported that 88 monitoring tools were completed over a three month period from 2/1/13 to 4/30/13. The findings included 95% compliance for the device being available in various settings and use. The facility monitoring data did not report on the following key compliance indicators: • Frequency of monitoring consistent with recommendations. • In the case a problem was identified, there was evidence of resolution (in the case that a problem was identified). Completed forms for communication-related monitoring conducted in the last month (2) were submitted for review. These were completed by the same clinician for two different individuals. It was not clear why only two forms were completed in May 2013. There was no way to determine what was monitored for either individual. Compliance was scored at 100%. There was no mechanism in place to ensure an accurate	Noncompliance

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		assessment of AAC use at the facility. The previous method for effectiveness monitoring was discontinued in April 2013 and a new system was not clearly established.	

Recommendations:

1. Continue to pursue speech therapists for the provision of supports and services related to mealtime and communication (R1).
2. Consider the development of an assessment audit system (R2).
3. Integrate all communication interventions into the ISP (R3).
4. Develop benchmarks to promote improvement in the timeliness of communication assessments (R2).
5. The clinicians should analyze the need for SLP supports and services and determine a reasonable number of FTEs/contract therapists to meet that need (R1 and R2).
6. More knowledge and experience related to the application of AAC to adults with developmental disabilities and physical/cognitive challenges is needed. The clinicians appeared to rule out this as an option based on cognition, limited used of the upper extremities, and initial lack of interest shown by the individual during the assessment, rather than recognizing the role of relevance, alternate access sites, environmental context and meaningful contextual training opportunities as effective methods in the development of AAC use in this population (R1-R3).
7. The therapists should provide real time modeling across environments as how to do this is not intuitive for direct support staff (R3).
8. Conduct audits of clinical documentation of direct communication interventions to ensure that this meets basic generally accepted practice standards (R3).
9. Establish a system to ensure that routine effectiveness monitoring is conducted for communication supports currently in place. The frequency of this should be established in the annual assessment (R4).
10. Review the current system of compliance monitoring to ensure that there are clear guidelines for frequency (R4).
11. Develop an operationalized policy (procedures) to clearly outline elements described in this report above (R1-R4).

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Individual Support Plans (ISPs) for: • Individual #390, Individual #483, Individual #441, Individual #383, Individual #570, Individual #595, Individual #121, Individual #462, Individual #365, Individual #500, Individual #504, Individual #34, Individual #170, Individual #169, Individual #80, Individual #393, Individual #161, Individual #449, Individual #436, Individual #847 o Skill Acquisition Plans (SAPs) for: • Individual #504, Individual #34, Individual #170, Individual #169, Individual #80, Individual #393, Individual #161, Individual #449, Individual #436, Individual #847, Individual #715, Individual #175 o Monthly review of SAP progress for: • Individual #504, Individual #170, Individual #169, Individual #393, Individual #161, Individual #449, Individual #436, Individual #847, Individual #175, Individual #715 o Functional Skills Assessment (FSA) for: • Individual #393, Individual #161, Individual #449, Individual #436, Individual #847 o Personal Focus Assessment (PFA) for: • Individual #393, Individual #161, Individual #449, Individual #847 o Vocational assessments for: • Individual #393, Individual #161, Individual #449, Individual #847 o Dental Desensitization plans for: • Individual #49, Individual #1, Individual #492, Individual #500 o Section S self-assessment, 5/17/13 o Section S action plan, 5/15/13 o Engagement monitoring form, 1/2/13 o Specific program objective implementation check form, 2/6/13 o Skill Acquisition Review Committee (SARC) policy and procedures, 1/10/13 o A list of training on skill acquisition programming, 11/12-3/13 o A list of skill training in the community, 11/12-4/13 o A summary of community outings, 11/12-4/13 o A list of individuals employed on-and off campus, undated o Description of on-and off-campus work programs, undated o A summary of treatment integrity checks, undated o Section S presentation book, undated o List of all individuals under age 22 and their current public school placement o ISPs, ARD/IEPs, attendance sheets, and progress notes for:

	• Individual #816, Individual #383, Individual #798 Interviews and Meetings Held: o Barbara Shamblin, Director of Education and Training o Polly Bumpers, John Parks, Troy Miller, Bertha Allen, and Rodney Price, Unit Directors o D'Amber Cooper, Education and Training Program Compliance Monitor o Casey Dahney, Active Treatment Coordinator o Norvell Starling, MSSLC liaison to MISD o Longhorn unit QDDPs and managers, 6/6/13 Observations Conducted: o Desensitization Committee Meeting o Skill Acquisition Review Committee (SARC) meeting • SAPs reviewed for: Individual #580, Individual #817, Individual #410, Individual #34, Individual #264, Individual #972 o Skill acquisition plan treatment integrity session for: • Individual #96, Individual #225 o Observation of implementation of SAPs for: • Individual #96, Individual #225 o Observations occurred in various day programs and residences at MSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals.
	Facility Self-Assessment: MSSLC's self-assessment included many relevant activities in the "activities engaged in" sections that were the same as those found in the monitoring team's report, and represented an overall improvement over the self-assessment submitted in the last review. For example MSSLC's S1 self-assessment appeared to be based directly on the monitoring team's report. The monitoring team believes, however, that some items in the self-assessment could better reflect the activities that the monitoring team assesses as indicated in this report. For example, S2 of the self-assessment appeared to focus on ensuring that functional skills assessments, vocational assessments, and preference and strengths Inventories contained information in the areas of living, working, and leisure. These are important topics, however, the focus of S2 in the monitor's report is on determining if assessments were clearly used to select individual skill acquisition plans. 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: • Modification of the SAP format (S1) • Initiation of a monthly Skill Acquisition Review Committee (SARC) meeting (S1) • Improvements in the percentage of SAPs reviewed with clear plans of generalization and maintenance (S1) • Improvements in the documentation of how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2) • SAP implementation improved (S3) • Development of new form to better track training in the community (S3) The monitoring team suggest that the facility focus on the following over the next six months: • Ensure that all SAPs are in the new format (S1) • 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) • Ensure that each SAP has a plan for generalization that is individualized (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 that it reflects both accurate implementation and documentation of SAPs (S3) • Identify target levels of SAP 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, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item includes 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, 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. Skill acquisition plans (SAPs) consisted of training objectives that were written and monitored by seven master teachers. 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. There were efforts, since the last review, to improve the overall quality of the SAPs at MSSLC. One positive development was the recent establishment of monthly Skill Acquisition Review Committee (SARC) meetings. The purpose of these meetings was to review SAPs and ensure that they contained all the necessary components of an effective plan discussed below. The monitoring team observed a SARC meeting and was impressed with the quality of the reviews, and believes these meetings could contribute to improvements in future SAPs. Additionally, the facility recently modified the SAP format to clarify the necessary components, and the training process. At the time of the onsite review, approximately 50% of the SAPs were in the new format. It is recommended that the new SAP format be expanded to all SAPs at MSSLC. The monitoring team reviewed 34 SAPs across 12 individuals. Four of those SAPs (those for Individual #847) were in the old format and, therefore, were not used in the evaluation of this provision item. In 24 of the 30 new format SAPs reviewed (80%), the rationale appeared to be based on a clear need and/or preference. This was similar to the last review when 83% 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 #449's SAP for managing a budget was that he wanted to have cable in his room, and therefore he needed to learn to budget his monthly expenses to pay for it.	Noncompliance

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		• The rationale for Individual #504's SAP of increasing his vocabulary was that a recent speech assessment indicated that increasing his vocabulary would enhance his communication. 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 #34's SAP of money management was that he was unable to make a purchase. Simply indicating that an individual cannot do something is not a sufficient rationale for choosing a SAP. There also needs to be a rationale for why this skill would be practical and functional for that individual. 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 • 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 new SAP training sheets contained all of the above components. Additionally, the new SAP format was associated with improvements in the maintenance and generalization plans. 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	

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		the end of formal training. Twenty-four of the 30 SAPs in the new format reviewed (80%) included a plan for generalization that was consistent with the above definition. This was a dramatic improvement over the last report when none of generalization plans were judged to be consistent with the above definition. Additionally, all 30 of the SAPs reviewed (100%) included a plan for maintenance that was consistent with the above definition. This represented another significant improvement from the last review when none of maintenance plans reviewed were judged to be consistent with the above plan. An example of an acceptable generalization plan was: • The plan for generalization in Individual #169's SAP of improving basic math skills stated, "…he will apply the skill at functional times in settings where he has the need to perform subtracting such as shopping and any other functional times." An example of an unacceptable plan for generalization was: • The plans for generalization for Individual #436's SAPs were conceptually correct but very general, and identical, for all four of his SAPS reviewed. They stated "…once he has met mastery level criteria in the training area, he will apply the skill in any setting where the skills would functionally occur." It is recommended that all SAPs contain generalization plans that are individualized and are consistent with the above definitions. At the time of the onsite review, the facility used various training methodologies, including total task training and forward and backward chaining. The new training format appeared to greatly clarify the training step and procedures. <u>Dental compliance and desensitization plans</u> MSSLC continued to make 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. A treatment plan based on the results of the assessment (i.e., a compliance program or systematic desensitization plan) was then developed. The interdisciplinary team that reviewed these plans and other interventions to decrease the use sedating medication for routine dental/medical procedures, discussed in the last report, continued to meet regularly. The monitoring team observed this meeting, which	

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		led to several discussions of nonrestrictive procedures for increasing compliance to routine dental evaluations in several individuals. A list of dental desensitization plans developed indicated that four plans were developed since the last onsite review. A review 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 of the 12 individuals reviewed (8%) had skill acquisition programs targeting the enhancement or establishment of communication and language skills. This represented a small increase in the number of communication SAPs at the facility from the last review when 5% 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). <u>Service objective programming</u> The facility utilized service objectives to establish necessary services provided for individuals (e.g., trips into the community). These were written and monitored by the QDDPs. The monitoring team did not review these plans in this provision of the Settlement Agreement because these were not skill acquisition plans (see section F for a review and discussion of service objectives). <u>Engagement in Activities</u> As a measure of the quality of individuals' lives at MSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals 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	

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		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 past reviews, 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 25 individuals engaged in various recreational activities at the gym. Many of the remaining individuals were often engaged in other typical activities, such as listening to music, talking to friends, watching television, or playing video games that did not require the active participation of staff. The monitoring team were particularly impressed by the level and quality of engagement in the day programing sites. The average engagement observed in the seven day treatment sites observed was 91%. Additionally, it was obvious that both the individuals and the staff were fully participating in the activities in this treatment site. 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 treatment sites. The table below documents this variability across settings. The average engagement score across the facility was 62%, about the same as that observed during the last three reviews (i.e., 64%, 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 continued to conduct its own engagement assessments. The self-assessment indicated that 91% of the 231 engagement scores that occurred since the last review were above 70%. The monitoring team's engagement assessment was considerably lower, indicating that 52% of engagement scores were above 70%. The monitoring team informally conducted engagement assessments with the education and training program compliance monitor (who routinely collected engagement data at the facility) to evaluate if the definitions of engagement were similar. The compliance monitor and monitoring team agreed on every occurrence and nonoccurrence of engagement. One potential reason for the difference between the monitoring team's engagement scores and the facility's is the location of sampled sites. In the monitoring teams sample, 67% of the engagement sites were residential. The facility indicated that seven	

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		individuals from the education and training department who all work during the first shift conducted the facility's engagement monitoring. Therefore, the majority of the facility's engagement assessments took place in the day treatment sites, which, as discussed above, appeared to have much higher engagement scores. It is recommended that MSSLC expand the collection of engagement data to all treatment sites throughout the facility and to times after 5 p.m. Another likely explanation for the differences between the facility's data and the monitoring team's could be due to differences in how engagement data were collected. As described above, the monitoring team used a momentary time sample. That is, engagement data were recorded based on what was seen at that moment of observation. On the other hand, the facility did a one-minute time sample. That is, the facility's observers watched a particular individual for one minute and recorded engagement if that individual was engaged at <u>anytime</u> during the 60-second observation period. It is generally acknowledged that the facility's method of data collection will yield a higher level of engagement than that used by the monitoring team. Although it is unlikely that both methods would yield the same percentages of engagement, they should both reflect changes in engagement across the facility. At this point, it is recommended that engagement targets for each home and day program site be established, and sites that do not achieve these targets be provided plans for improvement. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
W7	0/1	1:1
W7	2/2	3:2
W8	1/1	1:1
L4	1/4	3:4
L4	2/4	3:4
B1	1/1	1:1
B3	0/2	0:2
S2	5/5	3:5
GYM	25/25	7:25
W8	1/3	2:3
M1 and M2 common area	1/4	2:4
M7 and M8 common area	2/8	3:8
M7	0/2	0:2
M4	0/4	1:4
M3	3 /4	2:4
Life Skills	7/7	3:7
Life Skills	3/3	2:3

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Life Skills	6/6	2:6
Large Workshop	22/25	8:25
Greenhouse	2/2	1:2
Step Center Classroom	3/5	4:5
Step Center Classroom	5/7	3:7
Small Workshop	10/11	2:11
Woodshop	3/3	3:3
M1 and M2 common area	0/2	0:3
M1 and M2 common area	3/3	1:3
M4	1/4	2:4

Educational Services

The monitoring team again reviewed the ISD services provided to individuals at MSSLC who were entitled to educational services. A total of 74 students were receiving educational services from Mexia Independent School District (MISD) compared to 68 at the time of the previous review. All students continued to attend school at MISD school buildings in town. Most were at MISD's special education building (46 individuals), but others were at the regular high school (18 individuals, more than ever before), or at the regular junior high school (4, there had been none up to this point). The MISD-MSSLC integration process for having students become more and more included in the regular education program continued.

The MSSLC liaison to MISD reported a continued positive working relationship with MISD. MSSLC continued to send seven staff per day. Transportation for students was provided by MISD, however, MSSLC had a vehicle available for students who needed mid-day transportation (e.g., for medical appointments). The Longhorn unit QDDPs and managers also reported a very positive relationship with MISD. This included receiving feedback and reports from MISD, such as regarding a pizza party reward for those students who had no discipline referrals for six weeks. The number of students meeting criterion increased from 7 to 26 over the past two or three six-week periods.

MISD had hired a new superintendent. The MSSLC liaison did not know her name or anything about her. The MSSLC liaison also talked with the monitoring team about his concerns about in-school suspensions, but upon further discussion, it turned out to not be a serious problem because there were few occurrences (six over the entire school year) and most were for a short period of time.

The MSSLC liaison said that he attended every ARD/IEP meeting and that few others from MSSLC attended. The Longhorn unit QDDPs, however, reported that they attended every ARD/IEP meeting and actively participated, though only the signature of Mr.

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		Starling, the facility liaison to MISD, was on the attendance sheets for the three sampled students reviewed by the monitoring team. Nevertheless, the QDDPs descriptions of their caseloads, the school district, school programs, teachers, etc. indicated their knowledge of the public school program. All ISPs contained references to the individual's enrollment in public school and his ARD/IEP. Some included details about his academic performance (e.g., Individual #383). Each also contained an ISP action or objective regarding attending school. One ISP contained academic objectives for reading and math (Individual #816). All ARD/IEPs included multiple references to MSSLC and the student's residence at the facility. ARD/IEP reports cards and progress notes were reviewed by the QDDPs. They signed the report card to indicate their review and it was put into the active record. The monitoring team found multiple examples. This was great to see.	
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. Although improving, this item was rated as being in noncompliance because not all individuals reviewed had preference and vocational assessments, and it was not clear that assessments were consistently used to develop SAPs. At the time of the onsite review, all individuals at MSSLC had transitioned from the Positive Adaptive Living Survey (PALS) for the assessment of individual skills to the Functional Skills Assessment (FSA). As discussed in the last review, 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. 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. 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	Noncompliance

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		preferences and potent reinforcers. There was no documentation of the use of individualization of assessment tools to identify SAPs in any of the FSAs reviewed. To assess compliance with this item, the monitoring team requested ISPs, FSAs, preference and strengths inventories (PSIs), and vocational assessments for five individuals. A PSI and vocational assessment were not available for Individual #436. All individuals should have vocational assessments and PSIs. There were examples of how assessments and preferences were used to develop some SAPs. For example: • Individual #449's budgeting SAP indicated that he wanted cable in his room and needed to learn to budget his money so that he could pay for it. His FSA further indicated that, although he had basic math skills, he lacked the skill of budgeting. • Individual #393's ISP and PSI indicated that he enjoyed reading comic books. Additionally, his FSA indicated that he required some assistance to read. As a result of these assessments, a SAP was developed to teach him to read independently. This represented an improvement over the last review when none of the ISPs or assessments reviewed documented how assessments impacted the development of individual SAPs. In the majority of SAPs reviewed, however, it was not clear how assessments impacted their development. For example: • Individual #436 and Individual #449 had SAPs to increase time on task, however, there was no rationale for their SAPs in their ISPs, and their vocational assessments did not indicate that time on task was a concern. • Individual #161 had a hand washing SAP. His FSA indicated that he could not independently wash his hands, however, there was nothing in his ISP, or PSI that indicated a preference and/or need for this SAP. • Individual #436 had a SAP to do his laundry, but no mention in his ISP of any assessment results (e.g., FSA or PSI) that suggested that this was a practical SAP for him. The facility should ensure that assessments are consistently used, and documented, to select individual skill acquisition plans.	

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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	Additional SAP outcome data and a revision of treatment integrity data collection 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. Six months of SAP reviews were requested for 10 individuals. Only eight of the 30 SAPs reviewed had at least three months of data. The other 22 SAP reviews only included one or two months of data. Two of those eight SAPs (25%) indicated SAP progress. This represented a decrease from the last review when 35% of SAPs reviewed showed progress, however, given the small sample size, it is difficult to compare findings with much confidence. Despite the small sample, there was some evidence of data based decisions concerning the continuation, modification, or discontinuation of SAPs (e.g., Individual #504's budgeting SAP, Individual #175's operating the radio SAP). The facility should ensure that SAP reviews include six months of data. As in past reviews, the implementation of SAPs was observed by the monitoring team to evaluate if they were implemented as written. Both of the SAPs observed (i.e., Individual #96's SAP of money management, and Individual #225's SAP of identifying safety signs), appeared to be conducted as written. Additionally, the facility collected SAP treatment integrity data. At the time of the onsite review, treatment integrity assessment consisted of a direct observation of staff conducting SAPs and eight questions concerning the training, such as "did the training occur as scheduled? Additionally, one question included "Is the SAP being implemented as written?" The self-assessment indicated that 92% of the SAPs from January 2013 to March 2013 were implemented as written. The accompanying graph and the integrity data, however, indicated that treatment integrity was 100%. The monitoring team was encouraged by the facility's commitment to the collection of SAP integrity data to ensure that SAPs are consistently implemented as written. At the time of the onsite review, seven education and treatment staff conducted approximately 30 integrity checks a month. When questioned about the collection of the integrity data,	Noncompliance

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		however, the education and training program compliance monitor indicated that she was not confident of the reliability of these data, and indicated that the facility planned to review and modify the way in which SAP integrity data are collected, and retrain staff in conducting SAP integrity measures. The monitoring team agreed that the facility should review, and possibly modify, the treatment integrity tool to ensure it reflects both actuate implementation and documentation of SAPs. Additionally, it is recommended that the facility establish a schedule of SAP treatment integrity assessments, determine acceptable levels of SAP integrity, and provide performance feedback to staff to ensure that goal levels of SAP integrity are achieved.	
	(b) Include to the degree practicable training opportunities in community settings.	As discussed in past reviews, 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 and training activities in the community, and demonstrate the that those levels are consistently achieved. The facility was attempting to track the training of SAP objectives in the community. In the community training data provided to the monitoring team, however, it was impossible to differentiate training from leisure activities. At the time of the onsite review, the director of education and training indicated she was in the process of modifying the data system so that SAP training opportunities could more clearly be recorded. It is recommended that skill-training activities in the community be recorded so that trends could be tracked. Additionally, acceptable percentages of individuals participating in community activities and training on SAP objectives should be established, and the facility should demonstrate that these levels are achieved. At the time of the review, no individuals at MSSLC had supported employment in the community. This was the same as the number of individuals working in the community during the last onsite review.	Noncompliance

Recommendations:

1. Expand the new SAP format to all skill acquisition plans (S1).
2. 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).
3. All SAPs should contain individualized generalization plans that are consistent with the above definitions (S1).
4. Dental desensitization plans should be incorporated into the new SAP format (S1).
5. Expand the number of communication SAPs for individuals with communication needs (S1).
6. Expand the collection of engagement data to all treatment sites throughout the facility (S1).
7. Establish acceptable levels of engagement in each home, and attempt to achieve those levels of engagement (S1).
8. The MSSLC liaison should become more informed about what the Longhorn QDDPs are doing in regards to the educational services of the students on their caseloads (S1).
9. All individuals should have vocational assessments and PSIs (S2).
10. Ensure that assessments are consistently used, and documented, to select individual skill acquisition plans (S2).
11. Review (and possibly modify) the treatment integrity tool, establish a schedule of SAP treatment integrity assessments, track treatment integrity data, determine acceptable levels of treatment integrity, and provide performance feedback to staff to ensure that goal levels of treatment integrity are achieved (S3).
12. Skill training activities in the community should be recorded so that trends could be tracked (S3).
13. Acceptable percentages of individuals participating in community activities and training on SAP objectives should be established, and the facility should demonstrate that these levels are achieved (S3).

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: 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 regarding most integrated setting practices • Transfers and discharges, CM#4, 3/5/13 • All other admissions and placement department policies remained the same and were not re-reviewed o MSSLC organizational chart, 5/17/13 o MSSLC policy lists, May 2013 o List of typical meetings that occurred at MSSLC, undated but likely May 2013 o MSSLC Self-Assessment, 5/17/13 o MSSLC Action Plans, 5/17/13 o MSSLC Provision Action Information, most recent entries 5/21/13 o MSSLC Admissions and Placement Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 6/3/13 o DADS regulatory review 11/8/12, regarding delay in transition activities o Community Placement Report, last six+ months, 10/1/12 through 6/6/13 o List of individuals who were placed since last onsite review (33 individuals) o List of individuals who were referred for placement since the last review (40 individuals) o List of individuals who were referred <u>and</u> placed since the last review (3 individuals) o List of total active referrals (52 individuals), as of 6/4/13 o List of individuals who requested placement, but weren't referred (107 individuals) • Documentation of activities taken for those who did not have an LAR (no information) • Those who requested placement, but not referred due to LAR preference (3) o List of individuals who were not referred solely due to LAR preference (data were incorrect) o List of rescinded referrals (9 individuals) • ISPA notes regarding each rescinding (9 of the 9) • Special Review ISPA Team minutes for each rescinding (0 of the 9) o List of individuals returned to facility after community placement (2) • Related ISPA documentation (2 of the 2) • Root cause analysis (0 of the 2) 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 (8 of 60 individuals who moved since

	6/1/12, i.e., 1 year since placement) o List of individuals who died after moving from the facility to the community since placements of 7/1/09 (16, 1 since the last review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (49 individuals) o APC weekly reports • Statewide weekly enrollment report (4/26/13-5/17/13) • Detailed referral and placement report for senior management (quarterly, January 2013 and April 2013) • Example of inclusion of APC in weekly executive management meeting, 6/4/13 o APC Department meeting minutes (none) o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair, (0) ▪ Flyer for upcoming provider fair on 6/13/13 • Community tours, 9/25/12 through 4/26/13 (15 for 59 individuals including some tours only for family members/LARs; many individuals went more than once) ▪ One page reports about each group tour (for 12 of the 15 tours) ▪ Spreadsheet detailing the tours of each individual, undated ▪ Summary data from the above spreadsheet, undated • Meetings/trainings with local LA (1), 4/23/13 • Facility-wide staff trainings ▪ New employee orientation (none) ▪ Various trainings, handouts, and emails for staff and management • Family association meetings (1), 4/14/13 • Brochure and facility newsletter (1 each) o Description of how the facility assessed an individual for placement and three blank checklists 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), obstacles were included o Blank Avatar forms for rescinded referrals and for living options discussion, May 2013 o New blank CLDP format shell o List of individuals who had a CLDP completed since last review (the referral list) o Blank checklist used by APC regarding submission of assessments for CLDP, and completed checklists (29) o Blank form to help prompt IDTs to develop relevant SAPs during APC-PMM-IDT meeting o Completed day of move forms, with provider signature (2), and included in each CLDP packet (none) o DADS central office written feedback on CLDPs (1) o Data and presentation from the PET meeting presentation for section T (2), 1/17/13, 4/17/13 o Data and presentation from the QA report and QAQI Council presentation, section T, (1), 1/24/13 o State obstacles report and SSLC addendum, FY12 data, 2/26/13 o Facility community placement obstacles data, 94 individuals, 10/1/12 to 5/9/13

	o PMM tracking sheet, 6/7/13 o Post move monitoring helpful hints, May 2013 o Blank new post move monitoring form o Transition T4 materials: • List of 49 individuals • Packets for 31 individuals • Sample of 5: Individual #388, Individual #489, Individual #491, Individual #72, Individual #29 o ISPs for: • Set A: Individual #169, Individual #535, Individual #504, Individual #360, Individual #449, Individual #161 • Set B: Individual #157 (selected by APC), Individual #524, Individual #410, Individual #310, Individual #452 o ISPs recommended by PMM regarding selecting SAPs for community living: • Individual #325, 350 o Pre-ISP draft used during the pre-ISP meeting: • Individual #273 o Draft ISP used during the ISP meeting: • Individual #153 o CLDPs for: • Individual #128, Individual #196, Individual #340, Individual #367, Individual #332, Individual #135, Individual #94, Individual #248, Individual #426, Individual #80, Individual #880 (none in the new format) o Draft CLDP for: • Individual #53 o In-process CLDPs for: • Individual #371, Individual #55, Individual #56 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 #461: 90 • Individual #199: 90 • Individual #141: 45, 90 • Individual #370: 45, 90 • Individual #391: 45, 90 • Individual #382: 7, 45, 90 • Individual #520: 7, 45, 90 • Individual #423: 7, 45, 90 • Individual #116: P, 7, 45, 90 • Individual #543: P, 7, 45, 90 • Individual #137: 7, 45, 90

	• Individual #612: P, 7 • Individual #426: P, 7, 45 • Individual #146: 7, 45 • Individual #248: P, 7, 90 • Individual #135: P, 7 • Individual #94: P, 7 • Individual #367: P, 7 • Individual #251: 7 • Individual #454: P, 7 (new form) • Individual #196: P, 7 (new form) <u>Interviews and Meetings Held</u>: o Alynn Mitchell, Admissions Placement Coordinator o Jeanette Reaves, Post move monitor o Community provider agency, Daybreak, managers and staff: Betty Durham, Heidi Zerkle, Regina <u>Observations Conducted</u>: o CLDP meeting for: • Individual #53 o ISP and pre-ISP meetings for: • Individual #153, Individual #273, Individual #278, Individual #398 o Community group home visit for post move monitoring for: • Individual #248 o Self-advocacy meeting, 6/4/13 o Executive management meeting, 6/4/13
	Facility Self-Assessment The APC self-rated T1c, T1c1, T1c2, T1c3, T1d, T1e, T1h, T2a and T4 to be in substantial compliance. The monitoring team agreed with T1c2, T1c3, T1d, T1h, T2a, and T4, and also rated T2b to be in substantial compliance. The APC's self-assessment needed improvement if it was to be useful to her and her department. The two primary problems were an (a) an over reliance on the three statewide monitoring tools and (b) a failure to include in her self-assessment all of the aspects of section T that the monitoring team looks at and includes in this report. This has been a consistent statement from the monitoring team for many years now. Although the APC made some changes/improvements in some aspects of the self-assessment (T1b, T1c) much more work will be needed.

	Summary of Monitor's Assessment MSSLC made progress across much of section T. In addition to referrals and placements, there were 53 admissions since the last review; all via the court under Chapter 46B or Chapter 55. The facility was also beginning to implement state requirements regarding the assessment and designation of individuals as "high risk." 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 about 16%. Approximately 16% of the individuals at the facility were on the active referral list. 33 individuals had been placed in the community since the last onsite review. 40 individuals were referred for placement since the last onsite review. 52 individuals were on the active referral list. 2 individuals were returned to the facility after community placement. Of the 60 individuals who moved in the past 12 months, 8 were reported to have one or more untoward events (13%). There were no systemic issues delaying referrals (at the facility/local level) identified during this onsite review. Delays in transfer/activation of SSA and Medicaid benefits, however, delayed the implementation and/or receipt of some services for some individuals once they moved to the community. Transitions were not occurring at a reasonable pace. Of a sample of 11 of the 33 individuals placed since the time of the last onsite review, 3 (27%) were placed within 180 days of their referral. Of the other 8, 3 were placed 10 months after referral and 5 were placed more than one year after referral. Of the 52 individuals on the active referral list for community transition, 28 had exceeded the 180-day timeframe. There was a thorough living options discussion during 1 of the 3 ISPs observed (33%) and an adequate description of a thorough discussion was evident in 7 of the 11 ISPs reviewed (63%). The set of ISPs reviewed by the monitoring team included good statements about the decision made by the entire team for 7 of the 11 reviewed (63%). 11 of the 11 (100%) CLDPs included documentation to show that IDT members actively participated in the transition planning process. During the CLDP meeting, there was no discussion of pre- and post-move supports. This is probably the most important aspect of the CLDP meeting. The absence of the PMM's participation was also a problem. Improvement was needed in having the discharge assessments indicate how supports might be implemented in the new settings. The list of CLDP pre- and post-move supports continued to need much improvement. Even though there was some progress, many of the important categories and aspects of a comprehensive list of supports were not included in almost all of the CLDPs. Post move monitoring continued to be provided on time, thoroughly, and across the state. Follow-up occurred for almost all cases, though one case appeared to require more action from the post move monitor. Two post move monitorings were completed using the new iteration of the report form. The monitoring team listed a number of concerns regarding this.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	MSSLC made progress across much of section T. Alynn Mitchell, the admission and placement coordinator (APC) continued to be the director of the department. The previous post move monitor (PMM) took another position at the facility. One of the transition specialists, Jeanette Reaves, was now the new PMM. Two transition specialists remained; the third position was now vacant. In addition, there were two state-supervised transition specialists. Thus, there were seven full time positions in this department, more than a three-fold increase since the baseline review in 2010. The department was quite busy. In addition to handling referrals and placements, there were 53 admissions since the last review. All admissions were now only via the court system (called Chapter 46B or Chapter 55 admissions). Two homes were designated intake homes, W9 for adults and L9 for juveniles. The facility was also beginning to implement state requirements regarding the assessment and designation of individuals as "high risk." Any individual designated high risk could not be referred for placement. Only individuals who were admitted via the 46B or 55 process were allowed to receive this designation, however, not all individuals admitted via the 46B or 55 process had to be designated high risk (i.e., only those who met criteria when assessed). 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 about 16%. Approximately 16% 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. • 33 individuals had been placed in the community since the last onsite review. This compared with 28, 17, 25, 23, and 63 individuals who had been placed at the time of the previous monitoring reviews. o The number of community transitions showed an increasing trend. o This was the highest number of placements in any period except for the baseline review. • 40 individuals were referred for placement since the last onsite review. o This compared with 37, 21, 27, 18, and 44 individuals who were newly referred at the time of the previous reviews. o 3 of these 40 individuals was both referred and placed since the last onsite review. o This indicated that IDTs were continuing to make referrals. • 52 individuals were on the active referral list. This compared with 50, 42, 49,	Noncompliance

		and 73 individuals at the time of the previous reviews. o The number of community referrals showed a stable/increasing trend. • 107 individuals were described as having requested placement, but were not referred. This compared with 85, 157, 160, 168, and 40 individuals at the time of the previous reviews. o Of the 107 individuals who requested placement, but were not referred, 3 individuals had an LAR who made this decision. o Of the remaining 104 individuals, 63 were not referred due to behavior and/or psychiatric reasons, 13 for legal reasons, 10 were new admissions, and 17 were awaiting an updated risk assessment to be completed, and 1 while awaiting exploration of community options. o It did not appear that an appropriate review and/or appeal was conducted for those who did not have an LAR. The APC reported that reviews and/or appeals were conducted only if requested by the individual. She said that this rarely occurred. As recommended in the previous report, some sort of placement review or placement appeals process needs to occur if there is a lack of consensus in the IDT, as per state policy. • The list of individuals not being referred solely due to LAR preference contained more than 100 names. This compared to 2 and 9 individuals at the time of the previous reviews. o This was not an accurate count and should be completed correctly. • The referrals of 9 individuals were rescinded since the last review. This compared to 1, 7, and 20 at the time of the previous reviews. o Documentation was provided for 9 of the 9 individuals (100%) regarding the reasons for the rescinding, including ISPA notes. o A special review team, however, was not conducted to review the rescinded referrals. This had been done in the past. It was not clear why this was not continued. The APC reported that reviews and/or appeals were conducted only if requested by the individual and she said that this also rarely occurred. Some sort of special review should occur for rescinded referrals, as per state policy. o 1 of the 9 was rescinded due to funding not being available due to his diagnosis. This was since resolved and he was now back on the active referral list. o 2 the other 8 individuals themselves changed their preference and requested being removed from the referral list. o 2 of the 9 were referred in error by their IDTs prior to having had a required community risk assessment. o 1 was rescinded due to LAR preference. The LAR reported that he never approved referral. He had instead agreed to begin visiting providers and learning more about possible options.	

		○ The other 3 had increased medical problems and/or an appropriate provider with medical expertise could not be located. ○ An adequate review to determine if changes in the overall referral and transition planning processes at the facility was not conducted for the rescinded referrals. If done and if actions were recommended, the monitoring team would look for indication of implementation of actions. • 2 individuals were returned to the facility after community placement. This compared with 0, 1, and 0 individuals at the time of the previous reviews. ○ A placement review team was conducted for both of these (100%). The review was very adequate for the individuals, including what might be done for them if they were to be referred again in the future. The discussion for Individual #880, however, focused on what he needed to do in order to be referred again some time in the future, but provided no suggestions for what might be considered to reduce the likelihood of problems occurring again if he should be referred. ○ The reviews, however, did not consider what might be changed in the overall referral, transition, and placement process to reduce the likelihood of this type of occurrence in the future for all individuals at the facility. • 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 continued to be tracked and recorded (but not yet graphed). These data were now being obtained for at least a one-year period after moving. ○ Of the 60 individuals who moved in the past 12 months, 8 were reported to have one or more untoward events (13%). This included the two individuals who returned to the facility. Five involved police contact, behavior problems, and/or psychiatric hospitalization. Three involved medical hospitalizations. It was not clear to the monitoring team if the facility's PMM, APC, and IDT were notified and/or if they provided any support and assistance to the provider, even if it was past the 90-day post move monitoring period. ○ Of these, an adequate review was not conducted in any of the cases to determine if changes in the overall referral and transition planning processes at the facility should be made. This should not be a complicated or overly time consuming activity. The benefits may be very helpful to the APC, PMM, and transition specialists. If this were done and if any actions were recommended, the monitoring team would look for indication of implementation of these actions. • 1 individual had died since being placed since the last onsite review. This compares with 4 and 0 at the time of the previous reviews.	

		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 four monitoring reports, but had not been addressed by the facility. • 49 individuals were discharged under alternate discharge procedures (see T4). The monitoring team suggests that APC create a set of relevant graphs. A list of suggestions is provided below. The printouts can have more than one small graph on each page (e.g., three or four) to make the set of graphs easier to manage for the APC and for the reader. These graphs could then be part of the APC's QA program participation, such as in QAD-SAC meetings, QA reports, and QAQI Council (see sections E and T1f). The APC had created a number of these graphs. Of the 15 suggested graphs, she had created graphs for 8 (indicated by a check mark below). This was good to see. • √ Number of individuals placed each month or monitoring period • √ Number of new referrals each month or six-month period • √ 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 (e.g., CLDP planned, move date set, exploring possible providers) • 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 who had any untoward event happen after community placement each month o Cumulative number of each type of untoward event for all placements • √ Number of rescinded referrals each month or each six-month period • √ Number of returns from the community in each six-month period • √ Number of deaths in each six-month period • √ Number of alternative discharges (T4) • 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	

		Other activities None reported. Determinations of professionals 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. The monitoring team looks for indications in each professional's assessment, in the written ISP that is completed after the annual ISP meeting, and during the conduct of the annual ISP meeting. The monitoring team reviewed a set of ISPs (six) that the facility submitted as the most recent from each of the units. These, however, were from ISPs held in December 2012 through February 2013. The monitoring team, therefore, sought out more recent ISPs within the set of documents already submitted by the facility. Five were identified for ISPs held from late February 2013 through March 2013. For the purposes of this section of the report, the monitoring team will refer to the older set of ISPs as set A and the more recent set as set B. Overall, set B contained better information related to most integrated setting practices. More detail is provided below, in T1b1, and in T1b3. In assessments: Assessments were available for review for set A. Of these 5 ISPs reviewed (that had assessments attached), all of the assessments for 0 individuals (0%) included an applicable statement/recommendation. On the other hand, some of the assessments for all (100%) of the individuals included an applicable statement/recommendation. That is, all assessments done by nursing, OTPT, and speech included a specific statement and recommendation. Some of the assessments by psychiatry included a statement. Medical, vocational, dental, and others (e.g., vision, audiology, nutrition) did not contain a statement. It seemed that opinions were included by those disciplines that included a prompt or section that asked for the writer's opinion within the assessment template. This may be an easy way to ensure that this occurs for all disciplines. Assessments were not available for review for set B, however, the specific opinions of many IDT members were written into the ISP document, including QDDP, DSP, vocational, dental, OTPT, speech, and psychology. In the written ISPs: Of the 11 ISPs reviewed, 7 (63%) included an independent recommendation from the professionals on the team to the individual and LAR. Of these 11, each professional's opinion was given and described in 5 (45%) (i.e., all 5 ISPs in set B). The set B ISPs did a nice job of separately reporting the IDT professional members' joint opinion (i.e., without the individual and LAR), the individual's opinion, the LAR's	

opinion, and then the entire groups' ultimate opinion and recommendation.

Observation of ISP meetings: Of the 3 ISPs observed, 0 (0%) included an independent recommendation from each of the professionals on the team.

Individuals referred: In reviewing the 11 CLDPs, 11 (100%) individuals and/or LARs did not oppose transition to the community.

Referrals and Transitions

There were no systemic issues delaying referrals (at the facility/local level) identified during this onsite review. Delays in transfer/activation of SSA and Medicaid benefits, however, delayed the implementation and/or receipt of some services for some individuals once they moved to the community.

Funding availability was not cited as a barrier to individuals moving to the community.

Senior management at the facility was kept informed of the status of referral, transition, and placement statuses of individuals on the active referral list via a monthly update to the executive management committee by the APC. She presented the APC-QDDP monthly update on referrals and the most recent weekly enrollment report. This was an improvement since the last review. The monitoring team suggested that the APC occasionally give an update on positive outcomes that individuals have experienced after moving to the community.

Transitions were not occurring at a reasonable pace. The state's expectation was that once a referral was made, the transition to the community should occur within 180 days. The IDT was required to meet monthly to review and address the obstacle to transition after the 180-day window. The ISPA was then to be sent to state office.

- Of a sample of 11 of the 33 individuals placed since the time of the last onsite review (the individuals who's CLDPs were reviewed by the monitoring team), 3 (27%) were placed within 180 days of their referral. Of the other 8, 3 were placed 10 months after referral and 5 were placed more than one year after referral.
- Of the 52 individuals on the active referral list for community transition, 28 had exceeded the 180-day timeframe.
    - This compared with 14 and 26 individuals who were referred for more than 180 days during previous monitoring reviews.
        - Of these, 2 individual had exceeded one year. This compared with 3 and 5 individuals at the time of the previous reviews.
    - Some of the 52 were reported to be scheduled to move within the next month or two, however, a specific number or list of names was unknown to the monitoring team.

		○ 6 were about one month past the 180 days. ○ The individual who was on the referral list since 2010 was placed during the week of the monitoring team's onsite visit. • The number of 180-day referrals was stable, but not improving. • The APC reported that every two weeks, the QDDPs and the APC's staff completed two similar documents reporting on any activities related to the transition of each individual on the referral list. The monitoring team looked at these documents, as well as a number of emails between the APC's staff and the QDDPs. One of the documents was from January 2013 and was likely the APC's document. It had 16 columns, including a comments column that had some detail on activities over the past two or three months. The other document was from May 2013 and was likely the QDDP's document. It contained one line for each individual and gave the most recent referral status, but did not show any detail regarding the previous month's activities. ○ Overall, this appeared to be a good step towards having a simple way to monitor progress and activity across the large number of individuals on the referral list. ○ Overall, it appeared that actions were occurring for most individuals each month. ○ The monitoring team wanted to select a sample of individuals, however, the most recent document was the QDDP's, which only contained a single line per individual. For the next review, the monitoring team would like to review the detailed spreadsheet done by the APC. When reviewing these data, the monitoring team will look to determine that: ▪ There were reasonable activity and actions related to the transition and placement for XX of the XX (XX%) individuals. ▪ There were gaps of time (e.g., multiple months) during which little or no activity occurred for XX of the XX (XX%) individuals.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The state policy regarding most integrated setting practices was numbered 018.1, dated 3/31/10. A revision was completed and the DADS state office was expecting to disseminate it very soon. Thus, there was not a state policy that adequately addressed all of the items in section T of the Settlement Agreement. There was one new/revised policy since the last review. It was Transfers and Discharges, implemented on 3/5/13. It primarily dealt with the types of discharges addressed in provision T4. All other facility-specific policies regarding most integrated setting practices remained the same. The rating for T1b is based solely on the development of adequate state and facility policies. Sections T1b1 through T1b3 are stand-alone provisions that require implementation independent of T1b or any of the other provision items under T1b.	Noncompliance

	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the 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.	MSSLC had received state training and consultation on the newest iteration of the ISP process (also see section F). Further training was expected, especially given that the state was focusing upon two other facilities to further refine this new ISP process. <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. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted above in section F of this report, substantial compliance was not found for F1d, F2a1, and F2a3. Of the 11 CLDPs reviewed by the monitoring team, documentation indicated that the IDTs for 0 individuals (0%) included SAPs, and other supports, that were chosen with the individual's upcoming transition in mind. A SAP for Individual #135 was noted for identifying signs in the community, but it seemed that it was not directly related to his upcoming move. • The APC and PMM reported that they had recently begun to promote this by including a prompt in the APC-PMM-IDT meeting. It was one line that said to review SAPs for community transition training. • The PMM also said that she promoted this when she attended ISP meetings when an individual was referred and during any other IDT meetings regarding referral. Specifically, she suggested the recent ISPs for Individual #350 and Individual #325. The monitoring team reviewed these ISPs and found one paragraph in Individual #325's that was related to learning skills that would be relevant to community (but they were not then included in the list of action plans and objectives). Individual #350, however, had not been referred and there was nothing in his ISP or the other ISPA documents sent to the monitoring team that indicated so. <u>Obstacles to Movement</u> Of the 11 ISPs reviewed, 9 should have had obstacles defined (the other 2 were for individuals who were already referred). Of these 9 ISPs, 3 (33%) included an adequate list of obstacles to referral. The obstacles for these 3 were for behavioral, psychiatric, and/or maladaptive behavior. A fourth indicated that the team was concerned about how the individual would handle a transition, but no obstacles to referral were identified (Individual #452). A fifth individual's IDT could not come to agreement on whether to refer, but did not identify any obstacles (Individual #310).	Noncompliance

		Of the 3 annual ISP meetings observed, an adequate list of obstacles to referral or obstacles to transition was identified for 2 (67%) (Individual #153, behavior; Individual #398, risk assessment). Of the 3 written ISPs for which obstacles were identified, 2 (67%) included an action plan to address/overcome obstacles identified. Of these 2, 2 (100%) were individualized, were measurable, and included expected timelines (i.e., they were to participate in therapy and PBSPs). Of the other 6, there were no plans to address obstacles to referral at all. Individual #452's ISP did not identify obstacles, however, the ISP said that the IDT will contact family, will continue to give information to the individual, and will re-meet in six months. The monitoring team believes that the obstacle was that the IDT needed more information about community provider capability to support someone like Individual #452. Of the 3 annual ISP meetings observed, a plan to address/overcome the identified obstacles was included for 2 (100%). Of these, 1 (50%) was adequate (Individual #153). <u>Preferences of individuals and LARs</u> Of the 11 ISPs, 11 (100%) included an adequate description of the individual's preference and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). Three of the 11 individuals could not adequately express a preference. The ISP indicated this and what the IDT had done to try to make this determination. Of the 3 annual ISP meetings observed, the individual's preference for where to live was adequately described in 3 (100%), and this preference appeared to have been determined in an adequate manner for 3 (100%), that is, two were able to give a clear indication of preference and 1 was not. Of the 11 ISPs, 11 (100%) included an adequate description of the LAR's preference and how that preference was determined by the IDT, or indicated that there was no LAR. Of the 3 annual ISP meetings observed, there was an appointed LAR for three. Family member preference was discussed in all meetings (100%).	
	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 addressing some of these activities. <u>1. Individualized plan</u> • There is an individualized plan for each individual (e.g., in the annual ISP) that is	Noncompliance

		o Individualized and specifies what will be done over the upcoming year 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. MSSLC status: In reviewing 11 recently completed ISPs, 0 (0%) had a plan that addressed education about community options. These plans should be written in measurable terms to address the specific educational needs of the individual. Of the 11 ISPs, 4 stated that individual knew about community options and no additional education was necessary and 2 mentioned general activities, such as tours, the provider fair, and/or community activities, but were not written in measurable terms and did not appear to address the individual's specific needs. It may be helpful to add some prompts or headers to the ISP shell to help the IDT address each of the above four open bullets. 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 facility did hold a provider fair within the past 12 months (June 2012) and the next fair was planned for the week after this onsite review. As noted in the previous report, data and evaluations were collected from last year's fair. The APC was to use these data and information to help plan this year's fair, but that was not done at all. Thus, the facility did not complete the above bulleted activities. The monitoring team suggested that clinical and management staff be given the opportunity to attend the fair to learn more about community providers and various options that may be available to individuals. More education about community providers was needed, as evident during observation at ISP-related meetings. 3. Local Authority (LA) • Regular SSLC meeting with local LA • Apparent good communication and working relationship with LA • Quarterly meetings between APC/facility and LA • Agenda topics are relevant MSSLC status: The facility maintained good communication and a good working relationship with the LA, participated in quarterly meetings with the LA (though there was only one over the past six months, in April 2013), and ensured relevant topics were on the agenda for the LA meetings.	

		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. • Tours are for individuals or no more than four people • Individual's response to the tour is assessed (need methodology and indicators) MSSLC status: Approximately two tours continued to be available each month. Since the last review, it appeared that there were 15 tours and that a total of 59 individuals went on these tours (some of the tours were only for family members/LARs, and many individuals went on more than one tour). This compared with 11 tours for 37 individuals at the time of the last onsite review. An one page report was completed after each tour that had a couple of sentences about each individual's experience as well as a short paragraph about the tour overall for all individuals. At the time of the onsite review, there was no method for the QDDP and IDT to be informed about the individual's experience and response during these tours. This was corrected during the weeks following the onsite review. The LA was now to submit the information directly to the QDDP department at MSSLC. The APC had begun keeping a spreadsheet. It listed every individual, his or her referral status, and the number and type of tours he or she had gone on. The summary data reported the number of individuals who had gone on different types of tours. This was great to see and demonstrated that tours were occurring for individuals from all units at the facility. The data, however, were not all that meaningful because it included all individuals, back to March 2008, including 270 who had been discharged over that time. The APC should probably continue this data system because it provided good historical information. To make tour-related data useful to the APC, it should identify all current individuals at the facility for whom a tour was appropriate, what type of tour was appropriate, and whether or not each went on a tour that was appropriate. Percentages can then be calculated.	

		6. Visit friends who live in the community MSSLC status: Since the last onsite review, there were not visits by individuals to friends who had moved to the community. Of the 11 ISPs reviewed, visits to friends appeared to be appropriate for perhaps 7, however, the monitoring team could not determine if these individuals had any friends who had moved to the community. Even so, these types of visits were not offered to any individuals. This should be a relatively simple activity to add into the activities of those individuals for whom this would be appropriate. 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: Since the last onsite review, other educational activities for individuals and LARs/family members did occur during one self-advocacy meeting (observed by the monitoring team), did not occur during any house meetings for individuals, and did occur during one family association meeting (April 2013). 8. A plan for staff to learn more about community options MSSLC status: Since the last onsite review, educational activities for DSPs did not appear to have occurred at least once. Since the last onsite review, educational activities for clinicians did appear to have occurred at least once (a session on pre-selection provider visits, 50 staff across 4 sessions, February 2013; and sessions on 180 day placements and the admissions and transfer policies, 53 staff across 4 sessions, March 2013). Since the last onsite review, educational activities for managers and administrators did not appear to have occurred at least once. o The APC created and distributed a flyer about her department, and she wrote a periodic article in the facility staff newsletter. 9. Individuals and families who are reluctant have opportunities to learn about success stories MSSLC status: Since the last onsite review, there was no plan or actions for information about successful community placements to be shared with (a) individuals who were reluctant to consider community placement and (b) LARs who reluctant to consider community placement.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement	This provision item required the facility to assess individuals for placement. The facility reported that individuals were assessed during the living options discussion at the annual ISP meeting. Some checklists were available to the QDDP and IDT to assist with this process. In addition, a listing was given to the monitoring team showing every individual and his or her referral status.	Noncompliance

	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.	To meet substantial compliance with this provision item, the facility will need address the following four items to show that: • Professionals provided their determination regarding the appropriateness of referral for community placement in their annual written assessments. o As noted in T1a, but this was not yet being done for all assessments. • 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 Based upon the written ISPs, this did not appear to be occurring regularly. In some of the written ISPs, the determinations of various professionals were listed, but the monitoring team could not determine if they were presented during the meeting or if the QDDP had copied the statements from the written assessments. o This did, however, occur during 1 of the 3 (33%) ISP meetings observed by the monitoring team (Individual #278). • Living options for the individual were thoroughly discussed during the annual ISP meeting and, if appropriate, during the third quarter ISP preparation meeting. o There was a thorough living options discussion during 1 of the 3 ISPs observed (33%) and an adequate description of a thorough discussion was evident in 7 of the 11 ISPs reviewed (63%). ▪ The living options discussion observed at the ISP for Individual #278 did not include a thorough living options discussion, though it easily could have. The LAR stated that he did not want the individual to be referred and that MSSLC was home to him. Then, IDT members gave their opinions, the first three stating that he was not a good candidate for referral. Next was the SLP who stated that she saw no reason that he could not be referred and that he might benefit from living in a smaller environment where there were fewer people because he doesn't like crowds and noise. Further, she said that a clutter-free setting might be more comfortable for him because his vision was failing. Then the LAR became more open about the possibility. Unfortunately, when the LAR raised concerns about there not being 24-hour supervision in the community, no one corrected this misconception. Further, the next IDT member did not recommend referral and the QDDP closed by saying that they were not going to refer. It appeared that an opportunity to take steps towards exploring a community referral for this individual was missed. ▪ The IDT for Individual #398 during his annual ISP meeting	

		barely engaged in a living options discussion. Although the individual and his mother wanted to live near each other, or together, the IDT said that nothing could happen until a risk assessment was completed. Unfortunately, the IDT said that they would discuss again next year, rather than setting a date sooner than one year from now. ▪ The IDT for Individual #153, on the other hand, thoroughly engaged with him and his mother regarding what his options were, what he needed to do for his IDT to make the referral. o In general, the written ISPs in set B had better descriptions of the living options discussion than did set A. o The monitoring team's findings were somewhat similar to the more global findings from the APC's self-monitoring tool for the living options discussion. It might be beneficial to modify the living options observation tool to more accurately reflect the topics that need to be discussed and their quality. • 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 The set of ISPs reviewed by the monitoring team included good statements about the decision made by the entire team for 7 of the 11 reviewed (63%). A number of parts of provision T require the efforts of the QDDP and IDT (T1a, T1b1, T1b2, T1b3). Therefore, the monitoring team recommends that the APC and PMM work with the QDDP coordinator. It might even make sense to form a work group or special project. The use of prompts, changes in the blank template form, and discussion with the APC and the QDDP department are likely to result in more expedient progress in these areas. The APC reported in the opening session that a plan was developed to show this type of collaborative work, but the monitoring team found no evidence of this having occurred.	
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	The APC submitted 11 CLDPs completed since the last review. This was 31% of the 35 CLDPs reported by the APC as being completed since then. A set of in-process CLDPs was also reviewed. <u>Initiation</u>: 2 of the 11 (18%) CLDPs, but 3 of the 3 (100%) in-process CLDPs, seemed to be initiated right after the referral. The monitoring team looks for this to occur within 10 calendar days of referral. The newer MSSLC CLDPs included the data that the CLDP was initiated/created and dates when the CLDP was updated. This should be helpful to the APC and transition specialists in monitoring their continued updating of the CLDPs.	Noncompliance

	community living discharge plan in a timely manner. Such a plan shall:	Timeliness: 1 of the 11 (9%) CLDPs included documentation to show that they were updated throughout the transition planning process to indicate that ongoing activity was occurring for the individual's placement. Two others had some notes alluding to delays being due to pursuing foster care versus group home placement, and waiting for criminal activity charges to be dropped, however, these did not seem to adequately explain the delays. For all 10 of these 11, there were multiple-month long gaps of time during which it appeared that little or no activity was occurring. 2 of the 3 (67%) in-process CLDPs indicated ongoing activity. The third indicated a long gap from November 2012 to May 2013. It was good, however, to see that this CLDP was now getting updated. IDT member participation: 11 of the 11 (100%) CLDPs included documentation to show that IDT members actively participated in the transition planning process (i.e., visited potential homes and day providers, thoroughly discussed each potential provider, made changes in planning if necessary, responded to any problems exhibited by the individual). Coordination with LA: 11 of the 11 (100%) CLDPs included documentation to show that the facility worked collaboratively with the LA. This collaboration did not appear to be more than the LA's attendance at the CLDP meeting. On the other hand, there did not appear to be any activity that the LA was to engage in that he or she did not.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The 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. 0 of the 11 CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition by including documentation to show that all six of the activities listed in the below six bullets occurred adequately and thoroughly. • Training of community provider staff, including staff to be trained and level of training required. There was very little information about the training of community provider staff. Most CLDPs merely had one support that new staff would be trained on all of the aspects of the individual's support needs. Instead, the CLDP should indicate who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), the method of training (e.g., didactic classroom, community provider staff shadowing facility staff, or demonstration of implementation of a plan in vivo, such as a PBSP or NCP), and a competency demonstration component, when appropriate. For example, no indication of staff training was provided for Individual #367, and during the 7-day post move monitoring, the provider had	Noncompliance

		already failed to implement his positive reinforcement token system. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). This was not indicated in any of the CLDPs. • Assessment of settings by SSLC clinicians (e.g., OTPT, psychology, training and recreation). This was not indicated in any of the CLDPs. • Collaboration between provider day and residential staff is ensured. This was not described in any of the CLDPs. • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). This was not indicated. The IDT needs to consider this. • Collaboration between Post-Move Monitor and Local Authority staff. This was likely occurring, but not indicated in the CLDP. <u>Day of move activities</u>: 11 of the 11 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and all 11 indicated the responsible staff member. Documentation for 1 of the 11 (9%) indicated that the activities did indeed occur. This was for the most recent placement. The APC said that this was now part of their typical placement activity and would be included in future CLDP documents. <u>CLDP meeting prior to moving</u>: A CLDP meeting occurred for 11 of the 11 individuals (100%). The CLDP meeting for Individual #53 was observed by the monitoring team. It was led by one of the transition specialists. Of the seven aspects of the CLDP meeting listed below, items 1, 4, and 5 were observed. The monitoring team could not determine if items 2 or 3 had happened. Items 6 and 7 did not occur. Surprisingly, there was no discussion of pre-move and post-move supports (item 6). This is probably the most important aspect of the CLDP meeting. Further, ensuring that supports were adequately defined and required evidence specified was a problem in many of the CLDPs. The absence of the PMM's participation, therefore, was a problem. 1. Attendance by all relevant IDT members, community providers, and LA 2. Individual preparation occurred prior to the CLDP meeting, if appropriate 3. DSP preparation occurred prior to the CLDP meeting, if appropriate to do so 4. Individual participation occurred, or was facilitated, if needed 5. There was active participation by team members 6. All relevant pre-move and post-move (essential/nonessential) supports were discussed and any issues resolved 7. The post move monitor actively participated to ensure that supports were adequately defined and required evidence specified.	

		The CLDP meeting observed during the previous onsite review was the best that the monitoring team had seen. At that time, the monitoring team recommended that the APC and her staff continue to do what seemed to have led to this improvement, that is, having the PMM and transition specialists observe each other conducting CLDP meetings and providing behavior specific feedback. Unfortunately, this had been discontinued. The monitoring team offered to review an audiotape of another CLDP meeting that was to occur during the week subsequent to the onsite review, but it was never submitted to the monitoring team. The APC reported that descriptions of how the individual and the DSPs were prepped for participating in the CLDP meeting could be found in the CLDP documents. The monitoring team did not find this information in any of the 11 CLDPs. During the onsite review, no other CLDP, pre-CLDP, or transition meetings occurred.	
	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 pre- and post-move supports and other pre- and post-move activities. In 11 (100%) of the CLDPs, the facility identified all facility staff and other staff (e.g., LA, community provider staff) by name and/or title for each support. In 11 (100%) of the CLDPs, the facility identified specific timeframes/specific dates for completion and/or implementation for each support. In 11 (100%) of the CLDPs, signatures of facility director/APC, provider, and LA were included. In 11 (100%) of the CLDPs, other activities, names, and timelines/dates for other community living monitoring activities were included.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	11 of the 11 CLDPs (100%), included documentation that the plans had been reviewed with the individual and/or the LAR (or indicated that there was no LAR) as evidenced by • Signatures on CLDP • Narratives in the CLDP	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall	The APC continued the process that was in place at the time of the last review, that is, in preparation for the CLDP meeting, assessments were updated and summarized. In the newer CLDPs, much of these assessments were then fully inserted into the CLDP	Substantial Compliance

	have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	document and they were attached to the CLDP. For 11 of the 11 CLDPs reviewed (100%), all necessary assessments were completed. For 11 of the 11 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. For 11 of the 11 CLDPs reviewed (100%), all assessments were available to the APC and IDT prior to the final CLDP meeting. Each assessment should meet the following: • A summary of relevant facts of the individual's stays at the facility. o This was done sufficiently in the assessments. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. o This was done sufficiently. • Assessments specifically address/focus on the new community home and day/work settings; there are recommendations for the community residential and day/work providers. o This was done sufficiently. • Assessments identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. o Improvement was needed in having the assessor indicate how he or she might see the supports recommended being implemented in the new settings. This was done sufficiently for Individual #367. Each assessment section of the CLDP contained the APC's summary of the discussion and deliberations in a way that captured the content and intent of the participants.	
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-	The list of pre-move and post-move supports (previously called essential and nonessential supports) were identified in the CLDPs. The monitoring team continues to recommend that the APC and her staff use some type of checklist or guide to help ensure all supports were included. A checklist of items for this type of activity was suggested in previous monitoring reports. Further, the standards listed below could be used as a checklist by the APC and her staff. The list of pre- and post-move supports should meet the following standards. • The list should be comprehensive and inclusive, demonstrated by: o Sufficient attention paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ This was demonstrated in 3 of the 11 (27%) CLDPs. For the	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.	others, their serious behavioral, psychiatric, or medical histories were not adequately reflected in the supports chosen to reduce the likelihood of re-occurrence of problems. Most notable was the absence of detail regarding behavior support plans. o All safety, medical, healthcare, risk, and supervision needs addressed. ▪ This was demonstrated in 0 of the 11 (0%) CLDPs. CLDPs failed to include supports for food texture, GERD precautions, head of bed elevation, choking/aspiration risk, need for plexi-glass windows, or side effects of psychotropic medications. o What was important to the individual was captured in the list. ▪ There was improvement in this area and was evident in 8 of the 11 (72%) CLDPs. o The list thoroughly addressed the individual's need/desire for employment. ▪ This applied to 3 of the CLDPs. The supports listed, however, were adequate for 0 of the 3 (0%). Work was listed as very important to the success of these individuals, yet the supports only referred to looking for jobs, making applications, and working with DARS. Although these are relevant supports, history has demonstrated that these activities are often unsuccessful in finding employment for individuals. Further, the facility can probably do more to help with this process, such as ensuring the individual has a birth certificate and proper ID that will be required by employers. For instance, Individual #251's 7-day post move monitoring reported that he was doing very well, and was ready to go to work, but could not because he did not have an ID and he could not get an ID until a birth certificate could be obtained. Similarly, Individual #426 could not yet be paid because he did not have an ID. The case of Individual #543, however, was an example of the IDT trying to work on this prior to his transition. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included. ▪ This was evident in 1 of the 11 CLDPs (9%). This was disappointing because the referrals of many of the individuals was as direct result of the progress they had made and this progress was due, in part, to the use of positive reinforcement. Having a support that merely says "continue to implement the MSSLC BSP" was insufficient. o There were supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic,	

		community, communication, and social skills. ▪ This was seen in 1 of the 11 (9%) CLDPs. The others made no mention of skills or said that the provider would assess for this. Surprisingly, the teaching and maintaining of important replacement behaviors were not included as specific supports in any of the CLDPs. For some individuals, there was a support for MSSLC to give the provider the SAPs from the facility, but not for the provider to implement. The PMM, however, sometimes looked to see if SAPs were being implemented by the provider even though this was not required by the CLDP (e.g., Individual #248). o There were ENE supports for the provider's <u>implementation</u> 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. ▪ Important aspects of the BSP, PNMP, etc. should have their own support to highlight their importance and help ensure that the provider carries out these important aspects. This was seen in 0 of the 11 (0%) CLDPs. Examples of what should have been included were the interactional and positive reward components of BSPs and the most important details of the PNMP. o Topics included in training had a corresponding ENE support for implementation. ▪ Because there were few supports for training of staff, this was seen in 0 of the 11 (0%) CLDPs. There were some supports regarding training on adaptive equipment, but there was no corresponding support for the use and implementation of it. • The wording of every support is in appropriate, measurable, and observable terms. o Supports regarding appointments were written adequately. The supports for provision of services and activities, however, were not written in a way that was measurable, so that the provider and PMM knew how much, how long, how many, etc. In other words, there was need for observable reportable outcomes and a criterion for each support. • Any important support identified in the assessments or during the CLDP meeting that was not included in the list of supports, should have a rationale as to why it was not included. o This was evident in some of the CLDP narrative. In many cases, however, a recommendation in the assessment did not make it into the list of pre- and post-move supports with no rationale as to why not. For	

		example, many of the recommendations for Individual #94 did not end up as supports. • Every support should include a description of what the PMM should look for when doing post move monitoring (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur. o The evidence that the PMM should look for was included in all of the CLDPs, however, to observe or look at observation notes was likely insufficient. Interviews of staff and provider completion of a simple daily checklist were other ways that have been discussed by the monitoring team during previous reviews. In an effort to help the APC and her staff continue to improve the lists of pre- and post-move supports, comments regarding many of the CLDPs are provided below. Individual #128: • There were no supports regarding his textured pureed diet/food. Merely saying "follow dining plan" was insufficient and, moreover, didn't give any guidance to what the PMM should look for. • There were no supports regarding him receiving his favorite foods. • There were no supports regarding safety during meals by avoiding his grabbing and ingesting of other people's food. He was at high risk of choking and aspiration. Individual #196: • There was a support for his adaptive equipment to be delivered, but nothing about monitoring its use. This was especially concerning given that he had eight different adaptive equipment items. • The CLDP said that he could eat some his formula by mouth if he wanted, but there was nothing to that effect in the pre- and post-move supports. • Opportunities for participating in preferred activities had no criterion, that is, how often each should happen. This was an example of a support that lent itself easily to checklist monitoring, too. • His CLDP had three full pages describing his dental desensitization plan. This seemed curious because (a) the amount of space taken was disproportionate to other important supports, and (b) desensitization was (unfortunately) not included as a support. Individual #340: • He had a serious history of violent behavior, yet his pre- and post-move supports only said to continue his BSP. There were many important parts of his BSP that were likely critical to his success and, therefore, deserving of their own support.	

		Further, the evidence for the PMM was observation notes and data cards. This was insufficient because it did not address the implementation of the many important preventive and interactive components of his BSP. For instance, the use of positive reinforcement. • Stealing was an ISP objective, but not addressed at all in the support list. • There were only two pre-move supports, neither of which included any training for staff or the provider. • A job was noted as being very important, yet post-move supports only addressed assisting in searching for employment and to schedule an appointment with DARS. As noted in previous reports, this was insufficient. • It seemed that improving his reading skills was important to him, but it was not included in the supports list. Individual #367: • His CLDP did not include any personal preference items or activities. However, this was explained very well in the narrative, that is, that he did not want to include any because he wanted to wait and work this out with the provider. • It seemed that the IDT used the assessments and recommendations very thoroughly as they developed the pre- and post-move supports. • The IDT included supports to continue his quarter token system and to attend anger management counseling weekly. This was good to see (and the only example of such in the 11 CLDPs reviewed). Even so, much more was needed regarding his BSP. That is, he was very complicated, as evidenced by his history, by the seven pages of details in his psychology discharge assessment, and in the CLDP. For instance, the first few pages of the CLDP had a list of three replacement behaviors and 10 other things one might do to support him successfully, such as using praise and teaching coping skills. Individual #332: • His behavioral and psychiatric history included 17 hospitalizations, yet the only support to address his behavioral support was to "continue the BSP and data documentation." • He had preferences to mow the lawn, prepare meals, and go to restaurants, but none were included as supports. There were, however, supports for attending church and going to the movies, which were other preferences of his. Individual #94: • His supports included doing a sweep of all areas due to his pica. This was good to see. • The psychiatry assessment included some specific suggestions for the community psychiatrist to consider. This was also good to see.	

		• There were no supports regarding his ground diet and head of bed elevation requirements. Individual #248: • There were three pages in the CLDP about her behavior problems and how to support her, including four very good recommendations about how to interact with her, yet the only pre- or post-move support was to "continue the BSP." • There were no supports for her pureed diet, dysphagia, or heart and high blood pressure issues. • Interestingly, the assessments from the social and daily/residential departments had 15 preferred items and activities. The narrative of the deliberations indicated that none were included as supports because her LAR was confident that she would receive all of these and, therefore, there was no need to make an explicit support. The IDT should always include required supports. This helps to greatly increase the likelihood of their provision. Individual #426: • As was the case for all CLDPs, important replacement behaviors were identified, but were not included in the list of supports. For example, this individual had a replacement skill of learning to make decisions. • He was overweight. There were supports regarding taking his weight each month, but none about managing his weight, teaching healthy food choices, etc. • He wanted to improve his reading and math skills, but there was no support to address this. A support regarding going to the library, however, was certainly related to this, though more about having opportunities to read than improving his reading skills. Individual #80: • She had a long list of supports, including one for head of bed elevation, which was good to see included. • Training of staff on her feeding was in the CLDP narrative as being very important, but the IDT said there was no need to do any additional staff training because they'd trained one staff during the pre-selection visit. This seemed to be woefully insufficient. • The development of a personal relationship with the individual was very important, yet not at all addressed in the list of supports. • Important replacement behaviors of appropriate sensory stimulation and seeking attention were not included. • There were no supports about her diet being pureed and liquids being honey thick.	

		Individual #880: • The IDT reported that he had made exemplary progress in his behaviors and work ethic. Even so, he had a long history of serious behavioral and psychiatric problems, including multiple psychiatric hospitalizations and time in jail. Further, only a few months prior to his move (i.e., in July 2012), he had what was described as a rage and aggression incident at MSSLC. • There were important replacement behaviors that he was working on, many recommendations and comments were in the CLDP about the importance of how one should best communicate and interact with him, and many things were listed that were reinforcing to him. None of this was included in the list of supports. This provision item also requires that: • Essential supports that are identified are in place on the day of the move. o A pre-move site review was conducted for all individuals. A sample of 11 pre move site reviews were reviewed by the monitoring team (see documents reviewed) and all indicated that the pre-move supports were in place. • Each of the nonessential supports needs to have an implementation date. o Each nonessential support in the CLDP did have an implementation date.	
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.	The APC made some progress in that the materials related to this provision item were more organized than before. The monitoring team reviewed the APC's PET, QAQI Council, and QA report materials; graphic data summaries of the eight items check marked in T1a above; graphic presentation of the results of the three statewide self-monitoring tools; and one example of a completed statewide self-monitoring tool. There was not a written policy or written process for quality assurance to ensure the (a) development and (b) implementation of CLDPs. Data/information were being collected. The data being collected for the three statewide self-monitoring tools were not all relevant or valid (i.e., did not include everything that should be included, did not measure what they portended to be measuring). There was no indication if the data were being collected reliably. Data were reviewed and summarized, however, data were not analyzed. Actions were not taken as a result of analysis of the data. The data were included in the facility's QA program.	Noncompliance

T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. The report was issued to the Monitors and DOJ on 2/26/13, six months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. • There was some effort to separate a review of obstacles to referral from a review of obstacles to transition once an individual was referred. • DADS included a list of 12 initiatives it was continuing to support. In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). • The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: • Definitions: Section T.1.b.1 of the Settlement Agreement required that the facility "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." The state's report, however, defined obstacles "as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting." • Referrals: As indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. o It appeared facilities had interpreted Table 4 differently. In some instances, data were provided for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community. In other instances, it appeared these data were for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it. Both sets of information were important, but the reports certainly should have included the data on obstacles to referral for all individuals the Facilities supported. • Transitions: Surprisingly, adequate methodologies were not in place to collect data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. • Data: It was concerning that valid and complete data were not available. In	Noncompliance

		addition, the plans included in the facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, for many of the SSLCs, the plan to improve data collection involved retraining QDDPs and IDTs, as well as using a new data system. This was presented in general terms, and it was unclear if it was based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. • Assessment: The facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement required. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the facilities to address, and for which DADS' intervention was needed. • DADS initiatives: DADS included a list of initiatives, however, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals faced a "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals faced a "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statement about maximizing use of available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). The MSSLC-specific portion of this report identified the changing focus of admissions and placements at the facility. That is, that the non-high risk group of individuals were high priority to transfer to other facilities or to refer for placement. Given that many of these individuals had lived at the facility for many years, and given that many had complicated medical needs, placements were sometimes challenging to identify. Further, given that the population at the facility was moving towards a higher percentage of individuals labeled high-risk and/or behaviorally and psychiatrically involved, finding	

		appropriate placements was also going to be challenging. Therefore, the importance of referring an individual for placement when it is appropriate to do so, and the importance of identifying a full set of supports (T1e) should be a priority of the APC and her staff. Given that the QDDPs and IDTs have multiple responsibilities, ongoing training, contact, and involvement with the APC and her staff will be necessary. The MSSLC-specific portion of this report should also clearly differentiate issues related to referral for placement from issues related to transitioning to the community after being referred. The MSSLC-specific portion of the report correctly identified the new ISP process and how it was designed (but not yet fully implemented) to address some of these distinctions.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility	The monitoring team was given a document titled "Community Placement Report." It was dated for the (more than) six-month period, 10/1/12 through 6/6/13. 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

	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. Since the last review, 87 post move monitorings for 38 individuals were completed. This compared with 55 post move monitorings for 27 individuals, and 38 post move monitorings for 16 individuals at the time of previous onsite reviews. Post move monitoring occurred all over the state. The monitoring team reviewed completed documentation for 39 of the 87 post move monitorings (45%) for 21 of the 38 individuals (55%). Of the 39 post move monitorings, 12 were completed by Pamela Gonner, 12 by Dana Cotton, 9 by Jeanette Reaves, and 6 by Sarah Ham. <u>Timeliness of Visits</u>: For the 38 individuals, 87 reviews should have been completed since the previous review. Based upon a chart presented to the monitoring team, of the 87 required visits, 87 (100%) were conducted and 87 (100%) were completed on time (one appeared to have been late, but it turned out that the transition date on the spreadsheet was incorrect). Of the 39 post move monitoring forms reviewed by the monitoring team, all 39 (100%) included dates showing that they were completed on time. <u>Locations visited</u>: For the 39 post move monitorings reviewed, 37 (95%) indicated that the PMM visited the locations at which the individual lived and worked/day activity (e.g., day program, employment, public school) were visited. The 2 that did not include this information were the most recent reviews, completed on the newest iteration of the post move monitoring report. <u>Content of Review Tool</u>: 39 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. 2 of the 39 were completed using the newest iteration of the post move monitoring form. Below, the monitoring team provides five comments regarding this form: 1. There was no explicit indication of what locations were visited by the PMM. In one of the two, the monitoring team could glean this information from short entries regarding other aspects of the PMM's review. In the other, there was no	Substantial Compliance

		indication at all. The helpful hints document stated that all locations must be visited, but there was no requirement to report this. 2. The monitoring team could not determine what evidence the PMM was to look for, and what evidence the PMM examined "to assess whether supports called for in the CLDP are in place." It was, therefore, impossible to determine if the facility was substantially complying with this requirement for these 2 reviews. a. The monitoring team recommends that the post move monitoring form include these three pieces of information for each pre- and post-move support: (a) what evidence was to be reviewed, (b) what evidence was reviewed, and (c) the due date. b. Examples of evidence to be reviewed are direct observation, staff interview, provider documentation, and daily checklists completed by the provider. The PMM should then specifically indicate what he or she observed and reviewed, and whom he or she interviewed. 3. The monitoring team agrees with the helpful hints guidance for question 5, that is, when examining staff training, to not limit this to documentation. The monitoring team, therefore, recommends that question 5 be expanded to indicate that interview or observation of staff showed that staff were trained and knowledgeable. 4. The helpful hints document required a narrative about direct observation of the individual. This was done in one of the two. The monitoring team agrees with the helpful hints item for question 11 that requires a short comment be written regarding individual and LAR satisfaction, and the PMM's overall opinion about the community home and day site. 5. In the helpful hints document, the list of negative outcomes is not an all-inclusive list. It would be helpful to indicate that these are potential negative outcomes and others that might be identified should be reported and addressed. The post move monitoring report forms were completed correctly and thoroughly, as follows: • The checklist was completed in a cumulative format across successive visits for all 13 (100%) of the 21 individuals who had more than just the 7-day review. • Supports were verified, such as by indication of the evidence examined and the results of this examination, in 37 of the 39 (95%). • There was adequate justification for findings for each support in 37 of the 39 (95%). • Detail/comment was included in the evidence boxes at the end of each of the supports sections in 37 of the 39 (95%). Almost every support received some narrative comments. • LAR/family satisfaction with the placement (question #9) and the individual's satisfaction (question #11) were explicitly stated in the comments section in 38 of the 39 reviews (97%), taking into account that some individuals did not have	

		LAR or family involvement. • An overall summary statement of the post move monitor's general opinion of the residential and day/employment placements could easily be determined from the narrative comments provided by the PMM and/or was specifically indicated at the end of the report in 38 of the 39 (97%). The monitoring team recommends that the PMM include the names of provider staff who were interviewed to help the reader understand which staff were interviewed during the post move monitoring. This was done in 18 of the 39 (46%). Further, it appeared that the APC did not attend to any of the suggestions made in the previous report regarding improving the completion of these post move monitoring reports. <u>General status of individuals</u> Based upon the monitoring team's review, of the 21 individuals who received post move monitoring, 18 (86%) transitioned very well and appeared to be having good lives. The other individuals continued to exhibit problems or problems continued with their placements, providers, and/or supports (Individual #367, Individual #520) or had returned to the facility (Individual #80). As discussed with the APC, a root cause type of review needs to be done of any individuals whose placements failed or who had the kinds of problems noted in T1a. <u>Use of Facility's best efforts when there are problems that can't be solved</u>: In 12 of the 39 (31%) post move monitorings, additional follow-up, assertive action, and activities were required of the post move monitor. These were for 9 of the 21 individuals (43%). Examples of problems included documentation and data collection problems, failure to implement the token system, failure to find a counselor or psychiatrist, a missing nosey cup, and mild head hitting. There was appropriate follow-up and correction for 9 of the 12 (75%) visits for 8 of the 9 individuals (89%). For 1 individual (Individual #520), there were problems during all three of his post move monitoring visits. Problems were provider lack of knowledge of the individual, failure to provide a door alarm and ID bracelet, unsafe and lengthy porch repair, and lack of data collection. These problems were not corrected by the provider, however, it did not appear that the PMM did more than request the provider to correct these. That is, she did not involve the facility administration, IDT, or LA when these problems were not quickly corrected. The individual eventually was moved from his placement. <u>ISPA meetings after post move monitoring visits</u>: An ISPA meeting should occur after every post move monitoring during which a problem	

		or concern was noted by the PMM. An ISPA meeting was held and there were minutes/documentation of the meeting following 37 of the 39 (95%) post move monitorings.	
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 observed one post move monitoring at the home of Individual #248. The PMM, Jeanette Reaves, did a thorough and complete job post move monitoring. This was based on observation of the PMM's: • Examination and verification of every ENE support • Review of documents • Direct observation of the individual and staff • Staff interview • Individual Interview (as much as possible) • Gathering of information by directly observing/examining, not only by provider staff report • Professional interaction style • No use of leading questions • Assertive and tenacious in obtaining information The provider was Daybreak services. It was a very nice placement for the individual; she appeared to be happy and she was engaged in activities with the home staff. The home staff, Regina, and the home nurse, Heidi, were extremely knowledgeable about the individual. In addition to providing documentation regarding the CLDP supports, the provider kept a checklist on a number of supports, services, and activities.	Substantial Compliance
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	This item does not receive a rating.	

T4	**Alternate Discharges –**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	The APC reported that 49 individuals were discharged as per provision T4. The monitoring team was given the discharge reports for 31 of these individuals. The monitoring team reviewed a randomly chosen set of 5 of these 31. For future reviews, only a sample of these reports need be submitted to the monitoring team. <u>Compliance with CMS-required Discharge Planning Procedures</u>: Based on a review of the discharge summaries completed for these 5 individuals, all (100%) contained the all of the information consistent with the Centers for Medicare and Medicaid Services (CMS) requirements as follows below. Three of these individuals were transferred to another SSLC, and two were found to no longer be eligible for services. Documentation indicated that for all five individuals, there was: • Documentation in the individual's record that the individual was transferred or discharged for good cause. • Reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies). • A final summary of the individual's developmental, behavioral, social, health and nutritional status. • With the consent of the individual, parents (if the client is a minor) or legal guardian, a copy provided to authorized persons and agencies. • A post-discharge plan of care that will assist the individual to adjust to the new living environment.	Substantial Compliance

Recommendations:

1. The APC and her department should do a review (e.g., root cause analysis) of each rescinded referral, each failed placement/re-admission to the facility (if any), 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 (T1a, T2a).

2. Conduct some sort of placement review or placement appeals process for individuals who did not have an LAR, who requested placement but were not referred (T1a).

3. Create a correct list of individuals who were not referred solely due to the LAR preference (i.e., the IDT would have otherwise referred) (T1a).

4. Consider adding to the current set of graphs of referral and placement activities, and include them in the facility's QA program (T1a, T1f).

5. 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).

6. Document what activities the APC and her staff may have engaged in during the transition planning process (T1a).

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

8. Upon referral, the APC (or staff) should seek out the IDT and others to talk about what SAPs might be considered now that the individual was referred for placement (T1b1).

9. Obstacles to referral need to be identified, and action plans to address/overcome each individual's obstacles need to be measurable and with expected timelines (T1b1).

10. Implement the many activities required in T1b2 (T1b2).

11. Conduct and thoroughly describe the living options discussion in the ISP (T1b3).

12. Consider creating a section T and section F joint work group (T1a, T1b1, T1b3).

13. Provide more information on the training of provider staff (e.g., to whom, method, demonstration of competency), and regarding collaboration with community and provider clinicians (T1c1).

14. Conduct complete and thorough CLDP meetings (T1c1).

15. Assessments for discharge need to identify how supports might need to be provided differently or be modified in a community setting (T1d).

16. Ensure a list a list of pre- and post-move supports is comprehensive and inclusive (much detail in provided in the report) (T1e).

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

18. Improve the facility and statewide reports and assessments of obstacles (T1g)

19. Consider the monitoring team's comments regarding the new iteration of the post move monitoring report form (T2a).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o MSSLC Changes to Human Rights Committee Policy o MSSLC Policy: Human Rights Committee 3/1/13 o MSSLC Giving and Withdrawing Informed Consent Training Curriculum o MSSLC Giving and Withdrawing Informed Consent Determination Tool o Prioritized list of individuals without guardians who also lack functional capacity to render a decision regarding health or welfare o MSSLC Self-Assessment and Provision Action Information for section U o ISPs and Rights Assessments for: • Individual #120, Individual #535, Individual #101, Individual #98, Individual #475, Individual #360, Individual #449, Individual #424, Individual #161, Individual #169, Individual #560, Individual #43, Individual #492, and Individual #504. o MSSLC Section U Presentation Book o A Sample of HRC Minutes 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 Kim Williams, QDDP Director o Carla Wilkins, QDDP Educator/Compliance Officer o Joy Lovelace, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 6/3/13 and 6/5/13 o ISP preparation meeting for Individual #589 o Annual IDT Meeting for Individual #278 and Individual #398 o Longhorn Unit Meeting 6/4/13
	Facility Self-Assessment: MSSLC submitted its self-assessment. 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.

	Activities engaged in to conduct the self-assessment for U1 included: 1. Reviewed 100% (212) rights assessments from 10/1/12-3/31/13 determine if the new policy is being implemented correctly. 2. Reviewed two ISPs each month from 10/1/12-3/31/13 to determine if the ISP included discussion of giving and withdrawing informed consent. 3. Reviewed two ISPs each month from 10/1/12-3/31/13 to determine if the LAR or family member was included in the planning and discussion Activities engaged in to conduct the self-assessment for U2 included: 1. Reviewed list of all guardians whose paperwork needed to be renewed. 2. Reviewed each individual's need for an advocate or guardian completed at the annual Individual Support Plan meeting by the Interdisciplinary Team. The facility self-rated U1 and U2 as not in compliance. Based on the finding of the self-assessment, the HRO noted that progress was underway, but this provision was not in substantial compliance. Findings from the facility self-assessment were similar to findings of the monitoring team for the two provisions of section U. The monitoring team, however, looked not only for documentation of discussion by the ISP regarding capacity to give informed consent, but also looked at the quality of that discussion. The monitoring team agreed with the facility's compliance ratings for U1 and U2.
	Summary of Monitor's Assessment: The facility had not yet developed an adequate assessment process for determining the need for guardianship. IDTs were in the beginning stages of holding adequate discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent. This assessment process will need to be fully implemented for compliance with U1. Then U2 will be the next step, which is procuring guardians for individuals assessed as high priority. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The facility had not developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continued to need training to determine each individual's functional capacity to render informed decisions. • 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. A priority list of those in need of a guardian had been developed, and the facility was moving 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.	On 3/7/12, DADS State Office issued Policy #019: Guardianship. A second policy on consent remained in the development phase. The state is encouraged to finalize this policy, because it should assist the facilities in moving forward with regard to the implementation of the Section U Settlement Agreement requirements. Steps taken to address compliance with the requirements of section U included: • Implemented a new assessment tool to be used at the annual IDT meeting. • Rights assessments were reviewed by the human rights committee. • The HRO was notifying the QDDPs when rights assessments were not updated annually for individuals at the facility or when the HRC had questions regarding the rights assessment. She was tracking when issues were resolved. • The HRO continued to work with the self-advocacy group to provide training on becoming self-advocates. • The HRO sent reminders to guardians to renew paperwork when guardianship had expired. • The facility had distributed information regarding guardianship through the monthly facility newsletter. • The human rights officer worked with individuals and their IDTs to ensure protection of rights at the facility. She was actively involved at the facility and served as a resource to IDTs. Although the facility had developed a tool to assess capacity to give informed consent, the HRO reported that she was still waiting for the state's proposed assessment before moving forward with additional work towards meeting the requirements of section U. A sample of 15 ISPs and relevant assessments was reviewed to determine the adequacy of IDT discussion regarding individuals' ability to express their own wishes or make determinations regarding their health or welfare. None of the ISPs in the sample documented adequate discussion regarding decision making skills, the need for training, or the need for guardianship. None included an adequate discussion of the individual's ability to express his or her own wishes or make determinations regarding his or her own health or welfare. For example, • The ISP for Individual #424 did not document discussion regarding his ability to make informed decisions. It was noted that he was an adult without guardian and information regarding guardianship would be provided to his mother. • Individual #535's ISP did not include a statement regarding his legal status or discussion regarding the need for guardianship. It did include a summary of rights restrictions that were in place with a brief rationale for the restrictions. Access to his money was restricted due to a lack of money management skills. Although it was noted that he would receive money management training to remove this restriction, outcomes were not developed to address training on	Noncompliance

#	Provision	Assessment of Status	Compliance
		money management skills. • The ISP for Individual #98 stated that he was able to advocate for himself, but then noted that he was unable to give informed consent regarding medical, financial, restrictive practices, media, photo, and release of records. The team did not discuss training that might increase his ability to give informed consent or the possible need for legal supports in those areas. IDTs should consider alternatives to guardianship, such as a medical power of attorney, when it has been determined that an individual does not need a guardian, but could not make informed decisions regarding medical care. The annual IDT meetings were observed for Individual #278 and Individual #398. For each individual, the QDDP briefly reviewed the rights assessment with the team. Individual #398 was an adult with no guardian. The QDDP read through each section of the rights assessment and asked the team members if they felt that he had the ability to give informed consent in each area. Adequate discussion did not occur regarding decision making skills or training to address any barriers to making informed decisions. For example, the team responded "no" regarding whether or not he was capable of making decisions regarding medical care. The team did not discuss whether or not he then needed additional training to develop decision making skills or needed a legal representative to make medical decisions. The facility had not developed a prioritized list of individuals lacking both functional capacity to render a decision and a LAR to render such a decision based on an adequate assessment process. Limited progress had not been made towards meeting compliance with this provision through attempts to develop an adequate assessment process. IDTs were not holding thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. The facility was not yet in compliance with this provision.	
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	New guardianship had not been obtained for any of the individuals at the facility. The human rights officer was actively seeking guardians to renew guardianship on an annual basis. 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, though the current self-advocacy group was not very active and there was little attendance and participation from individuals.	Noncompliance

#	Provision	Assessment of Status	Compliance
	and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	There was a Human Rights Committee (HRC) at the facility that met to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of rights for individuals at MSSLC. The facility had not made progress in this area. Compliance with U2 will be contingent on the development of an adequate assessment process. It will be important for the human rights officer to continue to work with IDTs to ensure assessments are completed and teams engage in an adequate discussion of each individual's needs.	

Recommendations:

1. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR (U1).
2. Develop 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 such as developing training outcomes to develop and/or improve communication and decision making skills (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 facility-specific policies: • (no changes in the five facility-specific policies, so not reviewed again) o MSSLC organizational chart, 5/17/13 o MSSLC policy lists, May 2013 o List of typical meetings that occurred at MSSLC, undated but likely May 2013 o MSSLC Self-Assessment, 5/17/13 o MSSLC Action Plans, 5/17/13 o MSSLC Provision Action Information, most recent entries 5/21/13 o MSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 6/3/13 o List of all staff responsible for management of unified records o Active employee refresher training participation report, 1,259 employees, 7/25/12-6/5/13 o Employee signed acknowledgement of recordkeeping training, 3 samples, 4/9/13 o List of other binders or books used by staff to record data (two on list, none for section V) o Description of the MSSLC shared drive, undated, probably May 2013 o Tables of contents for the active records (updated 4/5/13), individual notebooks, and master records (no changes) o Active record check out monitoring sheet: blank set, and one completed for February 2013 o Examples of assessment tracking spreadsheets: two individuals, January 2013; two pages with many individuals April/May 2013 o Email about social histories, 1/2/13 o Email about nutrition IPN documentation, 9/27/12 o Individual notebook monitoring form, completed, 1/16/13, 4/5/13-4/16/13 (4) o One-page spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, 5/17/13 o Three-page spreadsheet showing training information regarding state and facility policies for each provision of the Settlement Agreement, undated but probably 5/17/13 o Blank tools used by the URC (checklist forms and statewide form), not updated recently o List of individuals whose unified record was audited by the URC, October 2012 to May 2013 o Completed unified record audit tools for 14 individuals for February 2013 through May 2013 • Active record and individual notebook • Master record • Statewide self-monitoring tool o Emails from URC requesting corrections be made, emails through May 2013 for reviews conducted through March 2013 (i.e., two month delay)

	o Electronic version of the March 2013 email from URC showing the color coding o Audit tracker, August 2012 through February 2013, a table showing if corrections were completed o Set of tabular and graphed data on documentation habits, April 2012 through March 2013 o Graphic presentations for one QA report section V, only presented once (2/14/13) o Description of how MSSLC addressed all six components of section V4 o Use of the active record during ISP/ISPA meetings, data, graphs, January 2013 through April 2013 o Active records and/or individual notebooks of: • Individual #883, Individual #69, Individual #54, Individual #562, Individual #517, Individual #875, Individual #224, Individual #619, Individual #170, Individual #505, Individual #53, Individual #273 o Master records of: • Individual #875, Individual #470, Individual #631, Individual #571, Individual #61 <u>Interviews and Meetings Held</u>: o Elaine Schulte, Director of Client Records o Sherrie Price, Unified Records Coordinator o Patty Thompson, Settlement Agreement Coordinator Assistant o Various staff, including Jane Brown, RN, Matt Lemon, RN, and Alisia Alexander, DSP II <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area o PET IV, CLDP, ISP, and pre-ISP meetings
	Facility Self-Assessment The content and procedures of the self-assessment remained almost identical to the self-assessment from the previous monitoring review. The comments made about the self-assessment in the last report continued to apply to this self-assessment. That is, the self-assessment needs to line up with what the monitoring team looks at. Further, section V3 should self-assess the conduct of the quality assurance audit process, not the results of it. Even so, the monitoring team agreed with the facility's self-ratings of V1 in substantial compliance and V2, V3, and V4 being in noncompliance.
	Summary of Monitor's Assessment: Continued progress was seen in all aspects of provision V, including substantial compliance with section V1. The active records continued to improve in areas including legibility and number of missing documents. Individual notebooks continued to be used for all individuals. Active treatment coordinators conducted monthly maintenance reviews of every individual notebook; 100% of the individual notebooks reviewed by the monitoring team contained the current ISP, IRRF, and IHCP.

	A master record existed for every individual at MSSLC. The director of client records needs to make a notation in the master record of efforts to resolve items that should be in the master record, but were not. Not all state policies were in place yet, though continued progress was evident (only provisions G, H, and S did not have a state policy). MSSLC now had two very good spreadsheets to address this provision. Five reviews (audits) were conducted in each of the previous six months. All audits were done by the one URC. An occasional inter-observer agreement should be conducted. The URC created some graphic presentations of her data, but they were not as comprehensive, informative, or useful as they should be. The monitoring team laid out a set of data graphs that should be created. A half-page description of how the recordkeeping department addressed V4 was given to the monitoring team. This was a good, though small, first step. The URC might solicit suggestions from the QAQI Council when she next presents section V at that meeting.

#	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.	Continued progress was seen in all aspects of provision V. The recordkeeping department remained under the direction of Elaine Schulte, the director of client records (DCR). Sherrie Price was now the sole URC, though Ms. Schulte planned to fill the currently open second URC position. Ms. Price took most of the lead in the management of recordkeeping activities and initiatives related to provisions V1, V2, and V4. Patty Thompson was the lead for section V2. The facility assigned staff to oversee the unified record. Home record clerks oversaw the active records, active treatment coordinators and unit administration oversaw the individual notebooks, and the DCR and URC oversaw the master records. The home record clerks continued to do a good job. There was some turnover in these positions, however, the clerks stepped up to fill temporary openings and other needs across the recordkeeping department. The active record audits that were being conducted by the record clerks had been discontinued. The director of client records should consider re-instating these once new clerks are hired, trained, and settled into their new positions. State policy and facility-specific policies remained the same as in previous reviews. The facility had a policy to maintain a unified record with the required components. The facility policy was consistent with DADS policy. The master records policy that was in draft form at the time of the last review was finalized and approved (Admin#12).	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility provided training to staff who documented in the unified record. This occurred in NEO. In addition, the annual refresher training on recordkeeping standards and expectations described in the previous report had continued and was now a part of the CTD department. The CTD department logged the names of every attendee, but could not determine the names of any staff who should have, but hadn't, taken the refresher. This should be corrected. Even so, from 7/25/12 through 12/17/12, 578 attended this refresher. The table of contents and maintenance guidelines were updated in May 2013 for the active record. They remained the same for the individual notebooks and master records. The active record changes were statewide changes from state office. Twelve of 12 (100%) individuals' records reviewed included an active record, individual notebook, and master record. <u>Active records</u> The active records continued to improve. The monitoring team reviewed active records in four of the five units at MSSLC. The monitoring team spoke with a number of staff about their experience with the active records. All reported that the active records were manageable and that it was easy to find documents when needed. The monitoring team's review of active records showed that for each record, more than 90% of required documents were present, current, and substantially in compliance with the requirements of appendix D of the Settlement Agreement. The URC's quality assurance audits described in section V3, and her delinquent documents ("D-list") data, had similar findings. Some positive activities since the last review: • All improvements noted in the previous two monitoring reports had maintained. • Aspects of the active record that were noted as needing improvement or attention in the previous report had been, or were being, addressed: o Legibility o Number of missing documents o Missing social histories o Active record check out/check in system: this was relatively new and was still being piloted. The URC was planning to begin trending the data she had been collecting. • Every active record was put into the state's new table of contents guideline order. This was no easy feat and the recordkeeping department's efforts are acknowledged by the monitoring team.	

#	Provision	Assessment of Status	Compliance
		• ISP assessments and PSIs were beginning to be tracked (in addition to ISP monthly progress notes and SAPs). Record clerks were using the QDDP ISP assessment list from each individual's ISP to determine if required assessments were in the active record. • The facility's "Delinquent Documents" ("D-list") monitoring and reporting continued. • Some departments were doing their own monitoring of their own parts of the active record (e.g., psychology). <u>Individual notebooks</u> Individual notebooks continued to be used for all individuals and as per state policies. The notebooks were to follow the individual throughout the day unless the individual was on routine supervision, in which case the notebook might be kept at the home or it might travel with the individual if he or she chose to do so. All staff questioned by the monitoring team were able to answer questions about the individual notebook, knew its whereabouts, and reported that the notebooks were easy to use and that making entries were a regular part of their jobs each day. Since the last review, the active treatment coordinators were assigned the monthly task of doing a maintenance review of the content and quality of every individual notebook. They completed a two-page form documenting each review. This appeared to play a large part in the improved quality of the individual notebooks. Moreover, 100% of the individual notebooks reviewed by the monitoring team contained the current ISP, IRRF, and IHCP. <u>Other binders/logs</u>: Data were not recorded in any other binders or logs at MSSLC that needed to be managed or reviewed by the recordkeeping department (as part of this provision). Bowel movements and food intake were recorded on a separate log, but were to be managed by the nursing department, not the recordkeeping department. The problems regarding binders and logs noted in the previous monitoring report were corrected. <u>Master records</u> A master record existed for every individual at MSSLC. All master records had been converted over to the newest format. The director of client records was to make a notation in the master record of efforts to resolve items that should be in the master record, but were not. She was not consistently doing so. This does not require much effort at all and needs to occur for all of the master	

#	Provision	Assessment of Status	Compliance
		records audited each month, for all new admissions, and for any other master records that might be examined by the director or her staff, in order to maintain substantial compliance. <u>Shared drive</u> The shared drive was described to the monitoring team. The recordkeeping department reported that all information in the shared drive also appeared in hard copy in the active record and/or individual notebook. <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 now had two spreadsheets to address this provision. These represented nice improvements from the previous spreadsheets. They were developed and managed by Patty Thompson. Not all state policies were in place yet, though continued progress was evident (only provisions G, H, and S did not have a state policy). One of the facility's spreadsheets listed all state policies, corresponding facility policies, if facility-specific customization of the state policy was done and, if so, what was the customization. It also included whether the facility-specific policy was reviewed by the state office coordinator, the date of approval by the MSSLC QAQI Council, the implementation data at MSSLC, and any other relevant comments. This was a very informative spreadsheet, though it was not yet completed. That is, Ms. Thompson now needs to seek out information, documentation, and evidence from across the facility to determine the status of all facility-specific policies. The second spreadsheet contained lots of information regarding the training of facility staff on state and facility-specific policies. This spreadsheet listed the same policies as in the first spreadsheet. This spreadsheet indicated who provided the training, what staff were required to be trained, how often they were to be retrained (if at all), the number of staff at the facility who were required to be trained, and the number of these staff who had been trained. There was also a space for comments. This was a very good way to track this information and was done, in part, in response to the recommendations in previous monitoring reports. The monitoring team recommends that Ms. Thompson include an "as of" date for each policy, so that the reader knows that the training data were valid/correct as of a certain date. As with the first spreadsheet, Ms. Thompson now needs to seek out information, documentation, and evidence from across the facility to determine the status of training of all state and facility-specific policies.	Noncompliance

#	Provision	Assessment of Status	Compliance
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Continued progress occurred for this provision item. Five reviews (audits) were conducted in each of the previous six months. All of the reviews were done in a fairly consistent manner and were neatly and clearly documented. The database of medical consultations continued to be used to assist the URC in conducting these reviews. The review consisted of four parts: • Completion of the table of contents review of each of the three components of the unified record (active record, individual notebook, master record) • Completion of the statewide self-monitoring tool • A listing of all needed corrections • Comments as needed All audits were done by the one URC. To control for any potential unintentional reviewer drift in rating, as recommended in the previous report, an occasional inter-observer agreement should be conducted, either by the other URC, the DCR, or the QA department. Inter-observer agreement should be done on the table of contents reviews as well as the statewide self-monitoring tool. The recordkeeping department should consider modifying the self-monitoring tool to incorporate both the table of contents tool and the statewide tool. A new version might even include items for rating whether the active record and individual notebook were accessible, locked when appropriate to do so, properly thinned and stored, and possibly other items that could help assess V4. For the table of contents reviews, the URC found about 10 needed corrections per review (March 2013), though there was some variability, as would be expected. All items needing correction were counted, including missing/incomplete entries and/or signatures. For the statewide self-monitoring tool, the URC used the information obtained during the table of contents review to make her ratings. Very few of the items were scored as no. This was good to see, however, in addition to recording a percentage score for the total tool, the URC should separately track and trend only those four or five items that regularly were scored as no. Otherwise, any improvement (or need for additional action) in these items will not be evident because these few remaining items will not be distinct from the larger set of items. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The URC then notified the relevant facility staff regarding these needed corrections. Then, she followed-up to determine whether corrections were completed. Emails to facility staff regarding corrections and requesting follow-up were done in a pleasant and professional tone. This was documented each month on a form called the audit tracker. The recordkeeping department followed corrections for two months. 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. Overall, this continued to be a good, straightforward system. The audit tracker, however, had not been done since the reviews for February 2013. It should be re-implemented. The URC created some graphic presentations of her data. This was good to see, however, it was not as comprehensive, informative, or useful as it needs to be, especially given the requirement for this to be a quality assurance process. The monitoring team below lays out a set of data graphs that should be created. This incorporates what was already being done by the URC, too. Any new graphs should be easy to set up and then each month's data can easily be added. There should 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. • Average score on a subset of self-assessment tool items that are most often scored no. This should be four or five items that are determined by the URC. • Total number of corrections need for all five reviews. • Percentage of items that were corrected within the specified two-month time period. o The URC was already calculating the above two bullets, but only reporting them for the current month on that month's audit tracker, separated by department. She should continue doing as she had been doing, but also make a month-to-month graph of the total facility data each month so that trending can be seen. • D-list report data (already being done, continue in the same manner). • Documentation data, including signatures, legibility, etc. Data were being graphed facility wide by type of error, and by unit for total. (No changes needed here, continue doing this in the same manner.) • Consider developing a data set and graphs for the V4 activities. Some data were being collected via the statewide tool (i.e., questions 7-10).	

#	Provision	Assessment of Status	Compliance
		All of these graphs should be included in the QA program's data inventory, QA matrix, and QA report. Also, once data are being collected, summarized, and graphed adequately, the DCR and URC (along with the QA department) should review these data to identify unresolved issues, analyze the data in more depth to identify specific issues or departments requiring more attention, and develop corrective actions, as appropriate, to address them. This would then be incorporated into the QAD-SAC meetings, QA report, and QAQI Council presentations.	
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.	In previous monitoring reports and during previous onsite reviews, the monitoring team detailed the six types of activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. The monitoring team reviewed all six with the URC and DCR. A half-page description of how the recordkeeping department addressed these six was given to the monitoring team. This was a good, though small, first step to telling the monitoring team how these items were being addressed. As indicated below, some activities were occurring. To further develop procedures for V4, the URC might solicit suggestions from the QAQI Council when she next presents section V at that meeting. 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> The monitoring team observed that: • In those notebooks that were observed by the monitoring team, a current ISP, IRRF, and IHCP were available in 100% of individual notebooks. This was a great improvement since the last review. • 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. • The URC answered a question about this during each of the five V3 audits, but the information was not summarized or detailed. • The URC reported that a new monitoring process was to be implemented to monitor the checking out and returning of active records. This had not yet been initiated, but seemed like a good idea. • The active records were available to the habilitation clinicians. Most IPNs were handwritten and completed at the time of the contact.	Noncompliance

#	Provision	Assessment of Status	Compliance
		2. Data are filed in the record timely and accurately 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 could be used to satisfy this requirement, too. The monitoring team observed that: • The D-list indicated that the frequency of important documents being late or absent from an active record was decreasing dramatically at the facility. This data should continue to be used to satisfy this item (#2) of V4. 3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure) The monitoring team observed that: • In looking at whether behavior data were recorded in a timely manner, 69% of data sheets reviewed had timely data. • There were blanks and omissions in the bowel management records. • Data sheets were not typically utilized for direct habilitation therapy, and many of the IPNs written were not data driven to reflect progress as a result of interventions. 4. IPNs indicate the use of the record in making these decisions (not only that there are entries made) • The URC reviewed IPNs while doing the five monthly reviews. She recorded her findings regarding this item (#4) 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 and then the findings summarized and reported for this item of V4. • Most entries were driven from a complaint by the individual or from a staff supporting the individual. The entries focused on the acute event or complaint, but rarely contained historical data of prior assessments. • Data were not consistently utilized to determine medication efficacy. In order for psychiatrists to make evidence-based driven decisions, staff inclusive of the psychiatrist, must routinely utilize records (e.g., seizure frequency/graph) in making treatment decisions. • The psychiatrists documented findings in the comprehensive psychiatric evaluation according to Appendix B, or in the form for psychiatry clinic including a psychiatric follow-up note, QPMR Annual, Q2 Clinic, Q3 Clinic, or Q4 clinic.	

#	Provision	Assessment of Status	Compliance
		5. Staff surveyed/asked indicate how the unified record is used as per this provision item • The V4 interviews were discontinued since the last review. It was unclear to the monitoring team if these were going to be re-started or if another method was going to be implemented to address this item (#5) of V4. • During random medication observations and interviews by the monitoring team, opportunities were presented to inquire of both RN and LPN staff how they used the individuals' records to assess, plan and evaluate care. The nurses reported they reviewed the Integrated Progress notes, physician orders, consults, laboratory data for problem oriented health concerns, and for quarterly and annual nursing assessments. 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 The intent of this item is for the record to be present and available, and that it is used when, and if, needed, such as if there is a question about data, diagnoses, incidents, etc. Many times, there is no need to open the record because IDT members do not need to access additional information. In other words, it is possible to satisfactorily meet this component if the record is present, not used, and no examples of it failing to be used when it should have been used. The monitoring team found the following: • The recordkeeping department took advantage of asking others who were already observing the ISP meetings for other purposes (e.g., ISP facilitators, others who were observing for sections T or F) to collect some simple data for the recordkeeping staff so that they did not have to also attend a meeting. Four questions/items were completed. A spreadsheet of this information was submitted, however, for the future, it should be summarized and perhaps graphed and included as part of the data set in the last bullet in the list of suggested graphs. The monitoring team and the URC discussed setting proper criteria for this, including monitoring the presence and appropriate usage of the active record when needed. Some of the four questions appeared to require that the IDT use the active record to receive a yes rating, however, it may be that there was no need for the IDT to refer to the active record. • Active records were present at Individual #53's CLDP meeting. The active records were present and used by the psychologist at Individual #153's ISP meeting and by the nurse and psychologist at Individual #273's pre-ISP meeting. • During an attended ISP meeting for individual #398, the unified record was present and utilized during the meeting to review historical data, and to make decisions about care, treatment and training. • All requested assessments were available to the IDT.	

#	Provision	Assessment of Status	Compliance
		• The QDDP provided IDT members with a draft ISP and IHCP at the annual team meetings. Data from assessments were entered into these two forms so that team members could reference current assessments when developing necessary supports. • Records were available during psychiatry clinic. Staff referred to the records, and reviewed documentation. For example, there was lack of similar diagnostics across disciplines in the unified record that was not reported by the IDT (until prompting from the monitoring team). • The paper work task placed upon the psychiatrists was apparent during the observations. Recommendations of reconstructing the psychiatric clinic process to facilitate documentation and sharing between disciplines are outlined above in section J.	

Recommendations:

1. The director of client records needs to ensure that the master records include documentation whenever the recordkeeping department has been unable to obtain a document after conducting a document search as per their own procedures (V1).

2. Consider re-instating the active record audits by the record clerks (V1).

3. Improve the CTD system so that it allows the recordkeeping department to determine the names of any staff who should have, but hadn't, taken the annual refresher (V1).

4. Complete state and facility policies for all provisions of the Settlement Agreement (V2).

5. Complete the contents of the two V2 spreadsheets (V2).

6. Occasional inter-observer agreement should be conducted for all parts of the unified record quality assurance audits (i.e., all three table of contents reviews as well as the statewide self-monitoring tool) (V3).

7. Create a simple, but complete set of data graphs (V3).

8. Include these graphs and data in the facility's QA data inventory, QA matrix, QA report, and review/analysis processes (V3).

9. Address all aspects of V4; build on activities already initiated; develop a data set for V4; get suggestions from QAQI Council (V4).

10. Ensure that ISPs and IHCPs are filed and accessible to staff implementing the plan within 30 days of development (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
CMQI	Continuous Medical Quality Improvement

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
DBW	Desirable Body Weight
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
EC	Environmental Control
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
EOC	Environment of Care
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
FAAA	Fellow, American Academy of Audiology
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
GIB	Gastrointestinal Bleed
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)
IA	Intelligent Alert
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
ICO	Infection Control Officer
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
ITB	Intrathecal Baclofen
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KPI	Key Performance Indicators
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

LLL	Left Lower Lobe
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
MCER	Minimum Common Elements Report
MCG	Microgram
MCP	Medical Care Plan
MCP	Medical Care Provider
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MDRO	Multi-Drug Resistant Organism
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
NFS	Non Foundational Skills
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
OH	Oral Hygiene
OHI	Oral Hygiene Index

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
PECS	Picture Exchange Communication System
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)
POC	Polypharmacy Overview Committee
POI	Plan of Improvement
POT	Post Operative Treatment
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
PUSH	Pressure Ulcer Scale for Healing
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
RLL	Right Lower Lobe
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
SBO	Small Bowel Obstruction
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
SOB	Shortness of Breath
SOP	Standard Operating Procedure
SOTP	Sex Offender Treatment Program
S/P	Status Post
SPCI	Safety Plan for Crisis Intervention
SPD	Sensory Processing Disorder

SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
ST	Speech Therapy
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
TFT	Thyroid Function Tests
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
UR	Unified Record
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