United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

Dates of Onsite Review: December 9-13, 2013

Date of Report: February 16, 2014

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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

In June 2013, the parties agreed that some modifications to monitoring could be made under specific circumstances. These include the following: 1) sections or subsections for which smaller samples are drawn, or for which only status updates are obtained due to limited or no progress; 2) no monitoring of certain subsections due to little to no progress for provisions that do not directly impact the health and safety of individuals; and 3) no monitoring of certain subsections due to substantial compliance findings for more than three reviews. For each review for which modified monitoring is requested, the State submits a proposal to the Monitor and DOJ for review, comment, and approval. This report reflects the results of a modified review. Where appropriate, this is indicated in the text for the specific subsections for which modified monitoring was conducted.

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, did a great job, before, during, and after the onsite review. She was again available, responsive, and helped ensure that the monitoring team was able to conduct its activities as needed. Her assistants, Regina Washington and Patty Thompson, were also extremely helpful to the monitoring team.

Management, clinical, and direct support professionals continued to be eager to learn and to improve upon what they did each day to support the individuals at MSSLC.

A brief summary regarding each of the Settlement Agreement provisions is provided below. Details, examples, and a full understanding of the context of the monitoring of each of these provisions can only be more fully understood with a reading of the corresponding report section in its entirety.

Restraint

- Good progress was made in all areas of this provision except for the addressing of the use of protective mechanical restraints.
- There were 263 restraints used for crisis intervention involving 58 individuals between 5/1/13 and 10/31/13. The number of restraint incidents decreased since the last onsite review. Three individuals accounted for 39% of all restraints.
- There were no dental/medical restraints provided by the facility.
- Additional training had been provided to psychologists, restraint monitors, nursing staff, and DSPs on implementing and monitoring restraints.
- The facility continued to collect and analyze data regarding restraint incidents. Data were used to develop corrective action plans when trends were identified.

Abuse, Neglect, and Incident Management

- Of 603 allegations investigated by DFPS, there were 16 confirmed cases of physical abuse, 2 confirmed cases of verbal/emotional abuse, 21 confirmed cases of neglect, and 1 confirmed case of exploitation.
- The facility reported that 155 other serious incidents were investigated by the facility during this same time period. The facility was still not adequately developing action plans to address trends on a systemic or individual level. The facility made general recommendations, but did not include measurable outcomes and follow-up to recommendations was not documented.
- The incident management department had recently begun providing incident and injury trend information to residential units and individual IDTs. The process remained in the initial stages and adequate action plans and follow up to action plans to track outcomes were not yet occurring.
- The facility review did not identify problems with investigations identified in D.3.f.
- The facility was not tracking outcomes to ensure that protections implemented following investigations were sufficient to reduce the likelihood of similar incidents from occurring.

Quality Assurance

- The QA program at MSSLC continued to make progress. There was not yet a complete and adequate data list inventory at the facility. Of the 20 provisions, 16 (80%) included data that could be used to identify trends as required in the wording of section E1; 11 (55%) included a wide range of data; 13 (65%) included what appeared to be key indicators; 0 (0%) described the data being collected; and 15 (75%) included a self-monitoring tool (or indicated that a self-monitoring tool was not used because of the extensiveness of the data, i.e., C and K).
- Important sets of data were not incorporated into the QA program, such as vandalism, confiscation of weapons, criminal activity, follow-ups to ISPAs, and the various data that were part of the unit directors' PIT meetings.

- Data from 19 of the 20 (95%) sections of the Settlement Agreement were summarized and graphed, but only some (9 of 20 [45%]) analyzed data (or presented data in any way) across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals.
- A facility QA report was created for six of the last six months (100%). There was little narrative analysis done in the report. The best examples were sections M, D, and V.
- The QAQI Council met at least once each month.
- An adequate written description did not exist that indicated how CAPs were generated. The sample of 4 CAPs appeared to have been implemented, however, not whether all aspects were implemented fully and in a timely manner. There was not yet an adequate system for tracking the status of CAPs.

Integrated Protections, Services, Treatment, and Support

- There was progress evident with the ISP process. Progress was observed towards integrating the risk identification process into the ISP process. At the ISPs observed, the risk discussion was much more integrated into the discussion regarding the individual's preferences, daily schedule, and support needs. All disciplines were observed working together to develop specific supports during annual team meetings.
- The monitoring team recommends a focus on the following activities during the next six months. All departments need to ensure that assessments are completed at least 10 days prior to the annual IDT meeting and are available to all team members for review. IDTs need to develop measurable outcomes and implementation strategies that will allow for consistent implementation and data collection. Outcomes should be developed based on each individual's known preferences that encourage greater exposure to a variety of activities (particularly in the community) and lead towards the acquisition of new skills based on known preferences and needs. All team members need to ensure that supports are monitored for consistent implementation and adequacy.

Integrated Clinical Services

- The monitoring team found some evidence of integration of clinical services, however, no true progress was appreciated. There were no new major initiatives specifically related to the integration of clinical services.
- There was evidence that integration was occurring, but it was not sufficient and this was acknowledged. There were some areas that were known to be particularly problematic. MSSLC did not have any formal plan, committee, or workgroup established to help move towards substantial compliance in this area.
- There was significant improvement on the part of the primary providers in the completion of the IPN entries for outside consultations. This improvement was noted with the implementation of the new IPN format in October 2013. Since this was a relatively new process, most records had very few notes in the new format.

Minimum Common Elements of Clinical Care

- The facility made limited progress in this area. A facility policy for the minimum common elements of clinical care was approved in May 2013.
- 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 also no review of any unscheduled/interval assessments.
- Clinical indicators were developed for osteoporosis, constipation, aspiration pneumonia, and diabetes mellitus. All of the clinical disciplines were required to develop metrics and audit tools for each indicator. The lack of an organized medical quality program resulted in an inability to assimilate this information into a cogent plan for the individual under review.

At-Risk Individuals

- Good progress had been made, through an improved understanding of the risk process by IDTs. The monitoring team observed the risk identification process at two ISP meetings and noted that the IDT held an integrated discussion regarding risk levels and supports needed to address risks identified.
- It was still evident that some important assessment information was not being collected and shared prior to the meeting that could contribute to team's ability to make informed decisions regarding appropriate interventions.
- Teams were not consistently documenting the completion of assessments and resulting recommendations. 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.
- IHCPs were not found in a majority of individual notebooks reviewed, so staff working directly with individuals did not have access to action plans developed through the ISP process.

Psychiatric Care and Services

- MSSLC met substantial compliance for five sections of provision J (J1, J2, J5, J6, J7). The department had a full time lead psychiatrist and five other full time equivalent board eligible/board certified psychiatrists, one of whom had fellowship training in child and adolescent psychiatry and had started at MSSLC during the week of the onsite review.
- There were areas where integration remained good (e.g., psychiatry and medical, psychiatry and nursing). There were areas where improvements in integration were necessary (e.g., psychiatry and psychology). 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 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.

- There was minimal pretreatment medication 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 had received pretreatment sedation elsewhere and then returned to MSSLC.
- The facility administered a Reiss screen for 100% of the new admissions to the facility and to everyone else at MSSLC. There was no evidence, however, that the Reiss screen was being utilized for change of status.
- 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. The neurologist had recently begun working through the IDT process to identify indications and target symptoms for the AED regimen.

Psychological Care and Services

- MSSLC maintained substantial compliance on four items (K2, K3, K8, and K11). Some improvements since the last review included an increase in the flexibility of the data collection system, continued work on ensuring that PBSP data ere recorded in a timely fashion, ere reliable, and that PBSPs were implemented as written. There was an increase in the percentage of individuals with monthly progress notes, the percentage of individuals with a PBSP that have a functional assessment and the percentage of individuals with a current annual psychological assessment.
- The monitoring team suggests that the MSSLC focus on expanding the collection of interobserver agreement (IOA), and treatment integrity to all individuals with a PBSP, and establish minimal frequencies of data collection reliability, IOA, and treatment integrity collection, and demonstrate that those frequencies of data collection are achieved. MSSLC should ensure that the progress notes consistently indicate 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. In addition, the facility should ensure that PBSPs contain replacement behaviors that are functional, that all PBSPs are clearly based on the hypothesized function of the target behavior, and 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.

Medical Care

- Progress was noted in some aspects of the delivery of health care services. There was improvement in staffing with the hiring of more full time physician employees.
- Individuals received the basic health care services. The routine screenings, preventive services, and core immunizations were generally provided. The compliance with most cancer screenings was very good and, overall, was increasing.
- Annual medical assessments were completed in a timely manner and the quality was generally improving. There was significant improvement in the completion of the quarterly assessments.

- Notwithstanding these improvements, there were continued concerns related to the follow-up of abnormal studies, monitoring individuals who received psychotropics and AEDs, and individuals with recurrent pneumonia. In many instances, monitoring was not completed as required.
- The external and internal medical reviews were completed on time and corrective actions were completed. However, there were conflicting reports related to the status of corrective action plans. There was no progress made in the development of a medical quality program and there did not appear to be any sense of urgency to do so.
- There was progress made in the implementation of the clinical guidelines issued by state office, but not all guidelines were implemented. MSSLC did not develop local policies based on state issued policies and guidelines.
- There was a great deal of disorganization associated with this review, data collection, and document organization. The ability to accurately collect and track data does influence the provision of services and will be important as a quality program is developed.

Nursing Care

- MSSLC sustained many of the improvements implemented at the time of the last monitoring visit and continued to make further improvements in all of the provisions of section M. Substantial compliance was maintained for M6 and achieved for M4.
- Fifty-two nurses were observed in various settings. Of that the total, 14 were RN Case Managers who were visible, and engaged with the individual during various times of the day and evening on the units
- A number of new action steps were implemented toward the development of new systems to improve upon assessments and in the delivery of quality care.
- The Infection Control Preventionist had made significant progress in the implementation of systems to assure systems were in place to facilitate identification of increases in infections, as well as clusters and outbreaks.
- Much work needed toward improvement in risk identification and monitoring, to ensure individuals and staff were knowledgeable of their identified risks, specifically those health conditions that were chronic.

Pharmacy Services and Safe Medication Practices

- For the most part, most practices were maintained. The pharmacists continued to document communication with prescribers, but there were problems with some communication, particularly when severe drug interactions were involved. Prospective lab monitoring continued to present challenges.
- There was improvement in timely completion of the QDRRs, but some were now completed ahead of schedule. Overall, the content was adequate, but additional work was needed in monitoring for the metabolic syndrome.
- Providers were rejecting a significant number of prospective recommendations. Retrospective recommendations appeared to be accepted, but QDRRs were not submitted for all providers.

- The MOSES and DISCUS evaluations were completed electronically and were being improperly executed. Adverse drugs reactions were reported and it was good to see that this was occurring.
- The medication variance program needed improvement.

Physical and Nutritional Management

- Provisions O1 and O3 achieved substantial compliance. During the PNMT meeting observed, the team demonstrated excellent discussion and problem solving. Their assessments and other documentation, clearly and concisely reflected this process.
- The Mealtime Coordinators were in place and appeared to understand their role, though it was unclear how they were trained. Despite this new support, there continued to be errors in implementation of Dining Plans across a number of homes. Approximately 50% of staff were able to answer questions about the supports they provided. Others required significant prompts before they could answer correctly.
- Positioning continued to improve, but there was an ongoing need to reposition individuals throughout the day and to check the position of individuals after mechanical lift transfers. Techniques used for re-positioning continued to be problematic.

Physical and Occupational Therapy

- There was continued, but limited progress. There were improvements in assessment content (e.g., in 45% of the elements of the assessments). On-time completion of assessments, however, continued to be problematic.
- There were few intervention plans and SAPs in place for individuals with OT/PT needs and those reviewed were not well documented with an assessment and discharge summaries.
- There was an audit system in place that did not appear to be effective in addressing the compliance of essential elements.

Dental Services

- Overall, given the significant changes in the clinic staffing, there was progress in the provision of dental services.
- Annual assessments were completed in a timely manner and the documentation found in these assessments was very detailed and thorough. Most individuals had recall visits on a quarterly basis.
- Routine prophylactic and restorative treatments were completed on campus and many individuals were referred off campus for more extensive treatment. MSSLC continued the practice of not utilizing mild sedation (anxiolysis) or any level of sedation. The facility was exploring the use of TIVA.
- There was still evidence of problems with oral care in the homes. The facility was taking new approaches to improve oral hygiene, such as implementing clinic programs for individuals with poor hygiene ratings and expanding the suction toothbrushing program.

Communication

- There was continued, but limited progress toward substantial compliance. Efforts to improve the content of communication assessments were noted. Though there were some improvements in assessment content, on-time completion of assessments continued to be problematic.
- There were few communication plans and SAPs in place for individuals with communication needs and for those with behavioral concerns in combination with severe communication deficits. Collaboration between psychology and SLPs appeared to be limited and no SLP had attended any Behavior Support Committee meetings.
- Continued effort was indicated to ensure integration of the recommendations in the communication assessment into the PBSP. This was also needed related to the ISPs as well.

Habilitation, Training, Education, and Skill Acquisition Programs

- There were several improvements since the last review. These included an increase in the number of SAPs written in the new format, a new engagement monitoring tool, the establishment of individualized engagement goals for each residential unit, and improvements in the documentation of how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans. The facility also showed improvement in the effectiveness of SAPs and the development of new form to better track training in the community.
- The monitoring team suggest that the facility focus on ensuring that all SAPs, including SAM/HIP and dental desensitization SAPs, are in the new format. Also, the facility should ensure that each SAP contains a rationale, individualized plans for generalization and maintenance, individualized, and individualized behavioral SAP objectives. In addition, the facility should document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of all skill acquisition plans. Finally, MSSLC should establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that those levels are achieved.

Most Integrated Setting Practices

- There were changes in the staff of the admissions and placement department; this competed with the facility's ability to make much progress in section T. As a result, the facility and DADS proposed reduced monitoring, or no monitoring, for some provisions because they were acknowledged to be in noncompliance before the initiation of this onsite review.
- Even so, many individuals at MSSLC were placed in the community, referred for placement, and involved in the transition planning process. The number of individuals placed was at an annual rate of about 18%. Approximately 16% of the individuals at the facility were on the active referral list. 29 individuals were placed in the community, 36 individuals were referred for placement since the last onsite review, and 53 individuals were on the active referral list.

- A small sample of CLDPs was reviewed. They were initiated in a timely manner and 3 of the 4 (75%) received ongoing attention during the transition period. Three of the 4 (75%) individuals moved within 180 days of being referred.
- CLDPs, however, did not yet identify a comprehensive set of steps the facility would take to ensure a smooth transition (T1c1), or include a comprehensive list of well-described pre and post move supports (T1e). The quality of the discharge assessments declined since the last review and needs to be improved, especially regarding detail on how to provide supports in the individual's new home and work settings.
- Sixty-nine post move monitorings were conducted for 29 individuals. A sample of 45 was reviewed. All were conducted within the required timelines and a post move monitoring form was completed. The form, however, did not describe the actions taken by the post move monitor in any detail so that the monitoring team (or any reader) could know what was done to ensure that supports were being provided as specified in the CLDP.
- Observation of a 90-day post move monitoring demonstrated that it was done thoroughly and correctly.

Guardianship and Consent

- The facility maintained a list of individuals determined by the IDT to need a guardian or advocate. Each individual on the list was assigned a priority rating of 1 through 6.
- Guardianship had not been obtained for any of the individuals deemed a priority in the past six months.
- IDTs continued to need training to determine each individual's functional capacity to render informed decisions.

Recordkeeping Practices

- Substantial compliance was maintained for provision V1. Progress was seen in V2 and V3, but not in V4. All 100% of the 1,500 staff were up to date on their annual recordkeeping refresher training.
- Eleven of 11 (100%) individuals' records reviewed included an active record, individual notebook, and master record. More than 90% of required documents were present, current, and substantially in compliance with the requirements of appendix D. The review of active records showed approximately 6 errors/missing documents per active record.
- Individual notebooks continued to be used for all individuals and as per state policies. A master record existed for every individual. Overall, the master records were in good shape.
- 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 URC notified the relevant facility staff regarding these needed corrections. Then, she followed-up to determine whether corrections were completed.
- The facility should review the department's 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. Analysis and resultant action are required for substantial compliance to be obtained for section V3.
- The URCs reported that V4 was not a focus in the last six months. Thus, no work was done to address the requirements of this provision and the facility was in substantial compliance with none of the six items.

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
o Training Curriculum: Restraint Monitor
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 Section C QA Reports for the past two quarters
o Sample of IMRT Minutes from the past six months
o Restraint Reduction Committee minutes for the past six months
o List of all restraint monitors and date training was completed
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 List of all individual that were restrained off the grounds of the facility
o List of all injuries that occurred during restraint
o MSSLC “Do Not Restrain” justification
o List of individuals with crisis intervention plans
o List of individuals with desensitization plans
o Sample #C.1: 30 records of physical or chemical restraint used in a crisis intervention for nine different individuals, drawn from the list provided in response to II.6 of the Document Request. Records drawn for this sample included: restraint checklist form, face-to-face/debriefing form, the individual’s Crisis Intervention Plan (CIP), if applicable, the documentation of any and all reviews of this use of restraint, and any addenda or changes to the ISP or Crisis Intervention Plan that resulted. The restraint incidents in the sample were:
<table>
<tr><th>Individual</th><th>Type of Restraint</th><th>Date</th></tr>
<tr><td>#595</td><td>Physical</td><td>7/26/13</td></tr>
<tr><td>#595</td><td>Physical</td><td>7/22/13</td></tr>
<tr><td>#595</td><td>Physical</td><td>7/2/13 @11:14 am</td></tr>
<tr><td>#595</td><td>Physical</td><td>7/2/13@ 10:42 am</td></tr>
<tr><td>#595</td><td>Physical</td><td>6/28/13</td></tr>
<tr><td>#595</td><td>Physical</td><td>6/21/13 @3:47 pm</td></tr>
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</td></tr>
</table>

#595	Physical	6/21/13 @3:42 pm
#595	Physical	6/21/13 @ 3:20 pm
#595	Physical	6/21/13 @ 1:01 pm
#595	Physical	6/16/13
#225	Physical	10/25/13
#225	Physical	9/25/13 @ 4:18 pm
#225	Physical	9/25/13 @ 4:14 pm
#225	Physical	9/2/13
#225	Chemical	7/23/13@8:55 am
#225	Physical	7/23/13 @ 8:35 am
#225	Physical	7/23/13 @ 8:29 am
#466	Physical	10/30/13
#466	Physical	10/27/13
#466	Physical	10/14/13
#466	Physical	9/8/13
#466	Physical	8/15/13
#466	Physical	8/12/13
#994	Physical	9/24/13
#157	Physical	10/23/13
#100	Physical	10/21/13
#139	Physical	10/15/13
#98	Chemical	9/26/13
#98	Chemical	9/24/13
#508	Chemical	8/22/13

- Sample #C.2: The following documentation was requested for a selected sample of 24 staff:
  - Their start dates
  - The dates they were assigned to work with individuals
  - Their training transcripts for two years showing :
    - PMAB training and
    - Training on use of restraints.

- Sample #C.3 chosen from the list provided in response to document request II.5.b. There were no reports involving restraint for medical/dental treatment, so no sample #C.3 was drawn. The facility provided a list of individual with protective mechanical restraint for this document request. The list was used for sample #C.7 (see below).

- A sample of the last 10 medical/dental restraints was requested by the monitoring team to include: the physicians' orders for the restraint including the monitoring schedule, the medical restraint plan, the restraint checklist, the documentation of the monitoring that occurred, any reviews of this use of restraint, and any applicable desensitization plan. The facility reported zero instances

of restraint for medical/dental treatment.

- Sample #C.4 (a subsample of #C.1) chosen from II.5a in response to the document request. The total number of chemical restraints for crisis intervention was 14, involving six individuals. Sample size was four, involving three individuals, or 29% of the chemical restraints and 50% of the individuals. Records requested included: the restraint checklist, Face-to-face/debriefing form, any reviews of the use of this restraint, and evidence of contact between the psychologist and physician prior to the use of the restraint. For the following:

Individual	Date
#225	7/23/13
#98	9/26/13
#98	9/24/13
#508	8/22/13

- Sample #C.5: Restraints off-campus.

Individual	Date
#466	8/15/13
#994	9/24/13

- Sample #C.6: The following documentation for a selected sample of individuals who were restrained more than three times in a rolling 30-day period:
  - Positive Behavior Support Plans (PBSPs),
    - Individual #225, Individual #18, Individual #848
  - Crisis Intervention Plans for:
    - Individual #225, Individual #18, Individual #848
  - ISPA meeting minutes for:
    - Individual #18, Individual #848

- Sample #C.7 was chosen from the list of 12 individuals for whom protective mechanical restraints were used in the past six months. This included review of Protective Mechanical Restraint Plans, Individual Support Plan (ISP), ISP Addendums, and ISP Action Plan.

Individual	Restraint type
#314	Abdominal binder and mittens
#285	Abdominal binder
#511	Abdominal binder
#293	Mittens
#61	Abdominal binder
#395	Abdominal binder

	Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, psychologists, and QIDPs in homes and day programs o Patrick Samuels, Incident Management Coordinator o Charlotte Kimmel, PhD, Director of Psychology o Don Morton, ADOP o Ramona Echols, Acting QIDP Director o Joy Lovelace, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 12/9/13 o Performance Evaluation Team Meeting II – 12/11/13 o Restraint Reduction Committee Meeting – 12/12/13 o Annual IDT Meeting for Individual #105 and Individual #160 o Pre-ISP Meeting for Individual #505 o Shamrock (S-5) ISPA meeting for three individuals
	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 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 297 (100%) crisis intervention restraints from 4/1/13 through 9/30/13 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. 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, C3, C4, and C8. The facility found that monitoring of restraints by nursing staff was not always completed within timelines required by state policy (C5). Additionally, the self-assessment found that PMR restraints were not adequately documented and reviewed (C6) and the facility was not meeting the requirements for review of individuals who were the subject of three or more restraints in a 30 day period (C7). Based on the samples reviewed, the monitoring team could not confirm compliance with C1 and C5 regarding the requirements for documenting and monitoring protective mechanical restraints. The monitoring team, however, found C6 and C8 to be in substantial compliance.

	Summary of Monitor's Assessment: Based on a list of all restraint data provided by the facility, there were 263 restraints used for crisis intervention involving 58 individuals between 5/1/13 and 10/31/13. The number of restraint incidents had decreased since the last onsite review when it was reported that there had been 293 restraints during the review period. Individual #595 (52 restraints), Individual #225 (27 restraints), and Individual #466 (23 restraints) accounted for 102 of the 263 (39%) restraints used for crisis intervention. A log of all dental/medical restraints provided by the facility included zero instances of dental/medical restraint from 4/1/13 through 9/31/13. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting compliance with the requirements of section C. • The facility continued to make good progress in the documentation and monitoring of restraints used for crisis intervention. • Additional training had been provided to psychologists, restraint monitors, nursing staff, and DSPs on implementing and monitoring restraints. • The facility continued to collect and analyze data regarding restraint incidents. Data were used to develop corrective action plans when trends were identified. Little progress had been made in addressing protective mechanical restraints.

<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>According to a list of all restraints implemented at the facility (Document II.5),

<table>
<tr><th>Type of Restraint</th><th>October 2012-March 2013</th><th>June 2013-November 2013</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>284</td><td>224</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>9</td><td>14</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>0</td><td>0</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>293</td><td>238</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>64</td><td>58</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>21</td><td>25</td></tr>
<tr><td>Medical/dental restraints</td><td>20</td><td>0</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>18</td><td>0</td></tr>
<tr><td>Protective mechanical restraints</td><td>No data available</td><td>12 individuals</td></tr>
</table>

<u>Prone Restraint</u>
a. Based on facility policy review, prone restraint was prohibited.

b. Based on review of other documentation (list of all restraints between 6/1/13 and 10/31/13) prone restraint was not identified.

A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises between 6/1/13 and 10/31/13. Sample #C.1 was a sample of 30 restraints for nine individuals, representing 8% of restraint records over the last six-month period and 16% of the individuals involved in restraints. The sample included 26 physical restraints and four chemical restraints. Sample #C.1 included the three individuals with the greatest number of restraints, as well as six individuals who were subject to 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.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Other Restraint Requirements e. Based on document review, the facility and state policies stated that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; 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 30 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. • h. In 30 of the records (100%), 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. • i. Facility policies identified a list of approved restraints. • j. Based on the review of 30 restraints, involving nine individuals, 30 (100%) were approved restraints. On 9/8/13, EMS personnel implemented an unapproved restraint type on Individual #466 after he attacked an EMT. MSSLC staff were not involved in the restraint at that point. k. In 30 of 30 of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. l. The facility reported that there were 12 individuals subjected to restraints classified as PMR. Eleven of those had binders and two had mittens. The psychology department was in the process of developing plans for those individuals to include a schedule of release, monitoring guidelines, and strategies for decreasing the use of the restraint. Six restraints were reviewed that were considered to be protective mechanical restraints (PMR) by the facility (Sample C.7). Of these, zero (0%) followed state policy regarding the use, management, and review of PMR. • The facility was using the Medical/Dental Restraint Checklist because the IDTs met and classified the restraints as medical and, therefore, used the Medical/Dental Restraint Checklist to document monitoring of medical	

#	Provision	Assessment of Status	Compliance
		restraints. • The facility had begun developing protective mechanical restraint plans (PMRP), as required by state policy #001.1 regarding the Use of Restraints. Two plans were being implemented and others had recently been approved for implementation. These plans should include a description of the individual's self-injurious behaviors, the type of restraint to be used, the restraint's maximum duration, and when to apply, remove, and monitor the restraint. o Individual #518's PBSP addressed the use of PMR. She did not have a PMRP in place. o Individual #395 did not have a PBSP in place. His ISP did not include guidelines for applying, removing, or monitoring his PMR. o Individual #61 had a PMRP in place that included strategies to fade the use of her restraint. The ISP and/or PMRP did not include replacement behaviors for staff to implement while out of restraint. Additionally, it did not include instructions for care of the restraint or monitoring of the restraint. o Individual #293's ISP indicated that the IDT had discussed his use of mittens. He did not have a PMRP, though his psychologist was developing a plan at the time of the monitoring visit. His ISP did not include directions for applying, removing, or monitoring his mittens. o Individual #511's ISP indicated that nursing staff would develop a plan to address her use of an abdominal binder to prevent removal of her G-tube. A PMRP had not been developed. Her ISP did not include staff instructions for applying, removing, or monitoring of her abdominal binder. o Individual #285 did not have a PMRP or PBSP in place. His ISP did not address applying, removing, or monitoring of his abdominal binder to prevent removal of his G-tube. The facility made good progress towards compliance with C1 regarding the documentation of restraints used for crisis intervention. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure that all IDTs are holding adequate discussion regarding the use of protective mechanical 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.	

#	Provision	Assessment of Status	Compliance
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The 26 physical restraint records involving the seven individuals in Sample #C.1 were reviewed. Five individuals in the sample had a Crisis Intervention Plan that defined the use of restraint. a. For the individuals involved in physical restraint who had a Crisis Intervention Plan (Individual #595, Individual #225, Individual #466, Individual #994 and Individual #157), 24 of 26 (92%) 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. • The restraint checklist provided to the monitoring team for Individual #595 dated 6/28/13, did not include release documentation related to that particular restraint. • The restraint for Individual #466 dated 8/15/13 lasted longer than directed in the CIP. He was restrained off campus for 25 minutes. Staff stated that he remained an imminent danger to himself. b. For two individuals who did not have Crisis Intervention Plans, two of two (100%) included sufficient documentation to show that the individual was released according to facility policy or as soon as the individual was no longer a danger to him/herself. Based on this review, the facility was in substantial compliance with C2.	Substantial 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:	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. • There was evidence that 19 of the 19 (100%) employees with current training	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. • 24 of the 24 (100%) had completed PMAB training within the past 12 months. • There was evidence that 19 of the 19 (100%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training unless documentation indicated that the employee was on leave. c. Based on responses to questions, five of five (100%) direct support professionals were able to describe specific behavioral intervention strategies for individuals that they were assigned to support to avoid restraint incidents. d. In 30 of the 30 records (100%), 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. Based on this review, the facility was in substantial compliance with the requirement for annual restraint training.	
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. All individuals in the sample had a Positive Behavior Support Plan in place. In review of Positive Behavior Support Plans for nine individuals in the sample, 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) (100%). c. In addition, facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention except for protective mechanical restraints for SIB. d. In 30 of 30 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders according to the "Do Not Restrain" list maintained by the facility. e. The facility reported that no restraints were used to complete routine medical appointments in the past six months. Therefore, the following metric was not applicable: In ___ of ___ restraint records reviewed (N/A), there was evidence that the restraint used was not in contradiction to the individual's medical orders according to the "Do Not Restrain" list.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		f. In 30 of 30 restraint records reviewed in Sample #C.1 (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. In reviewing documentation (Sample #C.3) for individuals for whom restraint had been used for the completion of medical or dental work: • g. ____ (N/A) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC)) approval and adequate consent; • h.____ (N/A) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. • i.____ (N/A) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled. Based on this review, the facility was in substantial compliance with C4.	
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	a. Review of facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. b. This training was competency-based. Ten staff had been deemed competent to monitor restraints as if 11/8/13. c. Based on review of document request II.19, for staff that performed the duties of a restraint monitor for restraints in the sample, seven of eight (88%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint in November 2013. An additional three employees were trained at that time. Based on a review of 30 restraint records (Sample #C.1), a face-to-face assessment was conducted: • d. In zero out of 30 incidents of restraint (0%) by an adequately trained staff member. New training for restraint monitors was provided November 2013. • e. In 30 out of 30 instances (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. • f. In 30 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • g. In 30 instances (100%), the documentation showed that an assessment was completed of the consequences of the restraint.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	There were significant improvements in the review of restraints by the restraint monitor. Restraint monitors were much more thorough in documenting information gathered after the restraint regarding events leading to the restraint and behavioral support strategies implemented prior to the restraint. Examples of good post restraint assessment documentation included the FFAD for: • Individual #225 dated 10/25/13 • Individual #225 dated 9/2/13 • Individual #466 dated 10/27/13 • Individual #466 dated 9/8/13 • Individual #100 dated 10/21/13 • Individual #139 dated 10/15/13 A sample of six PMR restraint records for which physicians had ordered alternative monitoring schedules was reviewed. • h. In six out of six (100%), the extraordinary circumstances necessitating the alternative monitoring were documented; and • i. In six out of six (100%), the alternative monitoring schedules were followed. 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 instances of restraint. Exceptions were: o A chemical restraint for Individual #508 dated 8/22/13. The nurse did not complete monitoring per schedule required during a chemical restraint. o A chemical restraint for Individual #225 dated 7/23/13. Monitoring following the administration of the chemical restraint was not documented. • k. Monitored and documented vital signs in 29 (97%). The exception was the chemical restraint for Individual #225 dated 7/23/13. • l. Monitored and documented mental status in 29 (97%). The exception was the chemical restraint for Individual #225 dated 7/23/13. Based on documentation provided by the facility, 10 restraints had occurred off the grounds of the facility in the last six months. A sample of two restraints was reviewed (sample #C.5). • m. Conducted monitoring within 30 minutes of the individual's return to the facility in one out of two (50%). Records that did not contain documentation of this included:	

#	Provision	Assessment of Status	Compliance
		o The restraint documentation for Individual #994 indicated that the nurse did not conduct monitoring of the individual until the following day. • n. Monitored and documented vital signs in two (100%). Records that did not contain documentation of this included: (not applicable) • o. Monitored and documented mental status in two (100%). Records that did not contain documentation of this included: (not applicable) Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months (there were none). For these individuals, • p. In (n/a) out of ____ , the physician specified the schedule of monitoring required or specified facility policy was followed; and • q. In (n/a) out of ____ , the physician specified the type of monitoring required if it was different than the facility policy. • r. In (n/a) out of ____ of the medical restraints (--%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. As described in C.5.m, the facility was not documenting PMR restraints on the Protective Mechanical Restraint form. Staff instructions were not in place for monitoring any of the restraints in the sample reviewed. Based on this review, the facility was not in substantial compliance with this provision. To gain substantial compliance with the requirements of C5, the facility will need ensure that: 1. PMRPs are developed for individuals with protective mechanical restraints. Monitoring of restraints should be documented on the Protective Mechanical Restraint Form as required by state policy. 2. A licensed health care professional monitors and documents vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint.	
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	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 28 (93%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. Although staff completing the restraint checklist were still not doing a good job	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	in many cases of documenting what was occurring prior to the behavior that led to the restraint, restraint monitors were including that information on the FFAD after interviewing staff involved. o The restraint documentation did not document what was happening that might have contributed to the behavior that led to the use of restraint for Individual #595 on 7/22/13 or 7/26/13. Both restraint forms indicated that he was upset for no apparent reason. • e. In 30 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. • 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; • 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 28 (93%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration). The longest physical restraint in the sample was 25 minutes. Exceptions were chemical restraints for: ▪ Individual #508 dated 8/22/13. Observations were not documented every 15 minutes for the first two hours as required by state policy. ▪ Individual #225 dated 7/23/13. There was no documentation of monitoring following chemical sedation. o j. In one (100%) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint; o k. In ___ (___%), the care provided by staff during restraint lasting more than 30 minutes, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. (there were none) • l. In 30 (100%), the level of supervision provided during the restraint episode; • m. In 26 physical restraints (86%), the date and time the individual was released from restraint; and • n. In 28 (93%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. Restraint checklists that did not include documentation of assessment by the nurse for injuries: o Individual #595 dated 6/21/13 o Individual #225 dated 7/22/13	

#	Provision	Assessment of Status	Compliance
		o. In a sample of 30 records (Sample #C.1), restraint debriefing forms had been completed for 30 (100%). p. A sample of zero individuals subject to medical restraint was reviewed (Sample #C.3), and in ____ (N/A), there was evidence that the monitoring had been completed as required by the physician's order or state policy. The facility reported no incidents of restraint for routine medical/dental appointments in the past six months. Sample #C.4 was a subsample of the four chemical restraints included in Sample #C.1. q. In four (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist or psychiatrist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Based on this review, the facility was in substantial compliance.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(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, 10 individuals were placed in restraint more than three times in a rolling 30-day period. This represented a substantial decrease from the last review when 17 individuals were placed in restraint more than three times in a rolling 30-day period. Three (i.e., Individual #225, Individual #848, and Individual #18) of these 10 individuals (30%) were reviewed by the monitoring team to determine if the C7 requirements of the Settlement Agreement were met. PBSPs, crisis intervention plans, and individual support plan addendum (ISPA) meeting minutes that occurred as a result of more than three restraints in a rolling 30-day period were requested for each individual. The facility indicated that no ISPA meeting documentation was available for individual #225 following more than three restraints in a 30-day period. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. This item was rated as being in noncompliance because not every individual who met criterion had documentation of a ISPA meeting following more than three restraints in a	Noncompliance

#	Provision	Assessment of Status	Compliance
		rolling 30-day period occurred, and the available ISPAs did not consistently reflect a discussion of each individual's adaptive skills and biological, medical, and psychosocial factors and an action plan for modifying them to prevent the future probability of restraint. One (i.e., Individual #18) of the two available ISPA minutes reviewed (50%) was judged to attain the above requirements because it reflected a discussion of adaptive skills, or biological, medical, or psychosocial factors affecting the behaviors provoking restraints and concluded that they did not affect his restraints. Individual #848's ISPA also indicated that medical issues might have affected the behaviors that provoke restraints, however, no discussion of possible action was documented in the ISPA. 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.	
	(b) review possibly contributing environmental conditions;	This item was rated as being in noncompliance because only one of the three ISPA meeting minutes requested (33%) reflected a discussion of possible contributing environmental factors, and suggestions for modifying them to prevent the future probability of restraint. Individual #18's ISPA meeting minutes indicated that loud environments may contribute to an increase in his dangerous behavior, and indicated that a particularly loud peer had been moved from Individual #18's residence. Individual #848's ISPA meeting minutes indicated that the absence of cigarettes may contribute to his dangerous behavior that provoked restraint, however, no suggestions for modifying that environmental condition was documented. Individual #225 did not have ISPA minutes to review. 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 review possibly contributing environmental conditions, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	Noncompliance
	(c) review or perform structural assessments of the behavior	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	provoking restraints;	the ISPA minutes reviewed (0%) reflected a discussion of potential environmental antecedents. In order to achieve substantial compliance with this provision item, the minutes from at least 85% of the individual's ISPA meetings following more than three restraints in a rolling 30-day period should review potential environmental antecedents, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	
	(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. This item is rated as in noncompliance because none of the ISPA minutes reviewed (0%) reflected a review of potential maintaining variables. 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
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	All three individuals reviewed (100%) had a PBSP to address the behaviors provoking restraint. The following was found: • All three 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), • Two (Individual #225, and Individual #18) of the three PBSPs reviewed (67%) specified the alternative, positive, and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, • All three of the PBSP specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint, and • All three of the five PBSPs reviewed (100%) contained interventions to weaken or reduce the behaviors that provoked restraint that was based on the functional assessment results. All three of the Individuals reviewed (100%) had a crisis intervention plan. The following was found: • For all three (100%) the type of restraint authorized was delineated, • For all three (100%) the maximum duration of restraint authorized was specified, • For all three (100%) the designated approved restraint situation was specified,	Noncompliance

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		and • For all three (100%) the criteria for terminating the use of the restraint were specified. In order to achieve substantial compliance with this provision item, MSSLC needs to ensure that at least 85% of PBSPs of individuals who were placed in restraint more than three times in a rolling 30-day period included functional (when practical and possible) replacement behaviors.	
	(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	This item is rated as in noncompliance because PBSP integrity data were not available for any (0%) individuals reviewed (see K4 and K11 for a more detailed discussion of treatment integrity at the facility). In order to achieve substantial compliance with this provision item, MSSLC needs to ensure that at least 85% of individuals with more than three restraints in a rolling 30-day period have treatment integrity data that indicates that their PBSPs was implemented as written.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	This item is rated as noncompliance because none ISPAs reviewed (0%) documented that the PBSPs were evaluated, and revised if necessary. In order to achieve substantial compliance with this provision item, 85% of individuals who were placed in restraint more than three times in a rolling 30-day period, should have evidence of a review (in the ISPA), and revision when necessary, of the PBSP.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The facility had a good restraint review system in place for all crisis intervention restraints. All restraints continued to be reviewed by the psychologist, unit directors, and IMRT. The facility continued to use video review of restraints to determine if restraints could have been avoided or implemented more safely. A sample of documentation related to 30 incidents of crisis intervention restraint was reviewed (Sample #C.1), this documentation showed that: • a. In 28 (93%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. The exceptions were: o Individual #994 dated 9/24/13. Review occurred on 9/30/13. o Individual #508 dated 8/22/13. Review occurred on 8/28/13. • b. In 28 (93%), the review by the IMRT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. The exceptions were:	Substantial Compliance

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		o Individual #994 dated 9/24/13. Review occurred on 9/30/13. o Individual #508 dated 8/22/13. Review occurred on 8/28/13. • c. In 30 (100%), the circumstances under which the restraint was used was determined and was 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 and/or psychologist 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. The IMRT did not document recommendations from their review for any of the restraints in sample #C.1. The IMRT should document any recommendations made during review of the restraint incident. The IDT, however, routinely met following restraints and made recommendations when warranted. • f. Of the ___ referred to the team, in _____ (N/A%) appropriate changes were made to the individuals' ISPs and/or PBSPs. (none were referred). A review of ISPAs for the individuals in the sample indicated that IDTs routinely met following restraint episodes and implemented changes in supports when appropriate. o An exception to this was for Individual #595 following a restraint on 7/26/13. The restraint monitor recommended that female staff should be removed from the environment during restraints. The restraint monitor made a recommendation to use male staff during restraint following a previous restraint on 6/28/13. There was no documentation to show that the IDT discussed this recommendation or that his BSP or CIP were revised to include this recommendation. Based on this review, the facility was in substantial compliance with review requirements. An adequate review process was in place, however, any recommendations made during the restraint review should be documented and tracked for follow up.	

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:** Documents Reviewed: 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 PET II Data Summary November 2013 o Incident Management Review Committee meeting minutes for each Monday of the past six months o Unit 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 Abuse/Neglect/Exploitation Trend Reports FY13 o Injury Trend Reports FY13 o ISP, ISPAs, IRRF, and PBSP for: • Individual #157, Individual #466, and Individual #589. 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 incidents and injuries since 6/1/13 o List of all ANE allegations since 6/1/13 including case disposition o A list of all investigations completed by the facility in the last six months. o List of employees reassigned due to ANE allegations o Documentation of employee disciplinary action taken with regards to the last three incidents of confirmed abuse or neglect. o Documentation from the following completed investigations, including follow-up:

Sample D.1.	**Allegation**	**Disposition**	**Date/Time of APS Notification**	**Initial Contact**	**Date Completed**
#42929769	Neglect (3)	Confirmed (1) Unconfirmed (2)	11/9/13 10:35 am	11/9/13 2:15 pm	11/19/13
#42924707	Emotional/Verbal Abuse (2)	Unconfirmed (2)	11/5/13 2:23 pm	11/7/13 9:54 am	11/14/13
#42922198	Emotional/Verbal Abuse Physical Abuse	Unconfirmed Other	11/2/13 5:48 pm	11/3/13 2:12 pm	11/12/13

#42914554	Neglect Physical Abuse (2)	Unconfirmed Unconfirmed (2)	10/27/13 8:16 am	10/27/13 3:50 pm	11/16/13
#42905414	Neglect	Unconfirmed	10/18/13 2:35 pm	10/18/13 3:35 pm	11/1/13
#42903796	Emotional/Verbal Abuse	Unconfirmed	10/17/13 11:26 am	10/17/13 4:25 pm	10/31/13
#42897845	Neglect	Unconfirmed	10/11/13 1:48 pm	10/13/13 3:42 pm	10/16/13
#42882000	Neglect	Unconfirmed	9/27/13 7:12 am	9/27/13 1:45 pm	10/7/13
#42875987	Emotional/Verbal Abuse Physical Abuse	Inconclusive Unconfirmed	9/22/13 10:38 pm	9/23/13 9:36 am	10/8/13
#42872584	Emotional/Verbal Abuse Neglect Physical Abuse	Unconfirmed Unconfirmed Unconfirmed	9/19/13 8:04 am	9/19/13 10:40 am	9/26/13
#42867284	Neglect (2)	Unconfirmed (2)	9/14/13 4:25 am	9/14/13 4:50 pm	9/24/13
#42860301	Neglect (6) Sexual Abuse (2)	Unconfirmed (6) Unconfirmed (1) Other (1)	9/8/13 8:43 pm	9/9/13 8:36 pm	9/28/13
#42852106	Neglect (2) Physical Abuse(1)	Confirmed (1) Inconclusive (1) Confirmed	8/30/13 4:36 pm	8/30/13 6:00 pm	9/19/13
#42840486	Neglect (2)	Unconfirmed (1) Confirmed (1)	8/20/13 8:48 am	8:20/13 2:35 pm	8/28/13
#42824881	Neglect (2)	Unconfirmed (2)	8/3/13 10:41 pm	8/4/13 11:55 am	8/13/13
#42822525	Neglect (8)	Unconfirmed (8)	8/1/13 1:03 pm	8/2/13 2:00 pm	8/14/13
#42787076	Physical Abuse	Confirmed	6/24/13 8:35 pm	6/26/13 9:50 am	7/11/13
#42789299	Neglect	Confirmed	6/26/13 5:20 pm	6/27/13 11:15 pm	7/26/13
#42706605	Physical Abuse (2)	Unconfirmed (1) Confirmed (1)	4/9/13 9:31 am	4/9/13 1:15 pm	7/18/1 methodological review
#42943510	Neglect	Referred back	11/21/13 5:46 pm		11/25/13
#42837323	Neglect	Referred back	8/16/13		8/26/13

			9:12 am		
#42819113	Neglect	Referred back – clinical issue	7/29/13 4:26 pm		7/30/13
Sample D.2	**Type of Incident**	**Date/Time Incident Occurred**	**Date/Time Incident Reported**	**Date Completed**	
#2656	UD Encounter with Law Enforcement	11/13/13 1:10 pm	11/13/13 1:20 pm	11/13/13	
#2571	Serious Injury	10/25/13 Unknown	10/28/13 4:02 pm	10/29/13	
#2537	Serious Injury	10/14/13 7:29 pm	10/14/13 10:40 pm	10/15/13	
#2517	Sexual Incident	10/13/13 10:45 am	10/13/13 11:09 am	10/14/13	
#2483	Serious Injury	10/7/13 6:30 pm	10/7/13 9:27 pm	10/7/13	
#2445	Serious Injury	9/23/13 7:20 am	9/25/13 6:55 pm	9/25/13	
#2422	Serious Injury	9/19/13 10:20 pm	9/20/13 1:33 am	9/20/13	
#2368	Serious Injury	9/11/13 8:40 pm	9/11/13 8:44 pm	9/11/13	

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, psychologists, and QIDPs in homes and day programs
- Patrick Samuels, Incident Management Coordinator
- Charlotte Kimmel, PhD, Director of Psychology
- Don Morton, ADOP
- Ramona Echols, Acting QIDP Director
- Joy Lovelace, Human Rights Officer
- 5 Unit Directors

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 12/9/13
- Performance Evaluation Team Meeting II – 12/11/13
- Restraint Reduction Committee Meeting – 12/12/13
- Annual IDT Meeting for Individual #105 and Individual #160

	o Pre-ISP Meeting for Individual #505 o Shamrock (S-5) ISPA meeting for three individuals
	Facility Self-Assessment: MSSLC submitted its self-assessment. Along with the self-assessment, the facility had two other documents that addressed progress towards meeting the 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. A sample of completed investigations was reviewed monthly using the statewide section D audit tool. Additionally, the facility looked at other documentation relevant to each provision. The facility's review of its own performance found compliance with 22 of 22 provisions of section D. Based on an agreement between the Settlement Agreement parties and the Monitors, only nine of the provisions were monitoring during this review. The monitoring team found the facility to be in substantial compliance with five of the nine provision items reviewed. The monitoring team was unable to confirm compliance with the requirements that: • Staff shall report all unusual incident to the SSLC Director and other agencies as warranted, consistent with Texas law (D2a) • Investigations be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent (D3g) • The facility will implement action to prevent similar incidents from occurring promptly and thoroughly, and track and document such actions and the corresponding outcomes (D3i) • Sufficient corrective action was taken to address trends of incidents and injuries (D4). The facility should review the monitoring team's findings for each provision found in noncompliance and consider further review of those provisions using similar methods used by the monitoring team.
	Summary of Monitor's Assessment: According to a list provided by MSSLC, DFPS conducted investigations involving 603 allegations at the facility between 6/1/13 and 11/7/13, including 213 allegations of physical abuse, 168 allegations of verbal/emotional abuse, 28 allegations of sexual abuse, 191 allegations of neglect, and three allegations of exploitation. Of the 603 allegations, there were 16 confirmed cases of physical abuse, two confirmed cases of verbal/emotional abuse, 21 confirmed cases of neglect, and one confirmed case of exploitation. The facility reported that 155 other serious incidents were investigated by the facility during this same time period.

	There were a total of 1109 injuries reported between 6/1/13 and 11/30/13. These 1109 injuries included 41 serious injuries. This was an increase from the 999 injuries reported the previous two quarters. The facility was not adequately addressing identified trends of injuries at the facility or individual level. The parties agreed that there be no monitoring for 13 of the 22 section D provisions that were found to be in substantial compliance during the last three or more monitoring visits. During this review, the monitoring team found the facility to be in substantial compliance with five out of nine provisions of Section D that were reviewed. Provision items found not to be in compliance were: • D.2.a: State required notification of the director and state office for all unusual incidents were not documented. • D.3.g: The facility review did not identify problems with investigations identified in D.3.f. • D.3.i: The facility was not tracking outcomes to ensure that protections implemented following investigations were sufficient to reduce the likelihood of similar incidents from occurring. • D.4: The facility was still not adequately developing action plans to address trends on a systemic or individual level. The facility made general recommendations regarding issues that were identified in the quarterly incident trend reports. Recommendations did not include measurable outcomes and follow-up to recommendations was not documented. The incident management department had recently begun providing incident and injury trend information to residential units and individual IDTs. The process remained in the initial stages and adequate action plans and follow up to action plans to track outcomes were not yet occurring. IDTs will need additional training on analyzing and addressing trend information.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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		

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	shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This was consistent with the requirements of the Settlement Agreement. According to a list of all abuse, neglect, and exploitation investigations provided in response to document request III.14, there were investigations involving 603 allegations of abuse, neglect, or exploitation conducted by DFPS at the facility between 6/1/13 and 11/7/13. From these 603 allegations, there were: • 213 allegations of physical abuse including, o 16 confirmed o 112 unconfirmed o 6 inconclusive o 63 unfounded o 3 referred back to the facility for further investigation o 13 pending outcome • 168 allegations of verbal/emotional abuse including, o 2 confirmed o 99 unconfirmed o 5 inconclusive o 46 unfounded o 4 referred back to the facility for further investigation o 9 pending outcome o 3 other (outcome unknown) • 28 allegations of sexual abuse including o 12 unconfirmed o 14 unfounded o 1 referred back to the facility for further investigation o 1 other (unknown outcome) • 191 allegations of neglect including, o 21 confirmed o 124 unconfirmed o 5 inconclusive o 11 unfounded o 16 referred back to the facility for further investigation o 12 pending o 2 other (unknown outcome)	Noncompliance

#	Provision	Assessment of Status	Compliance
		• 3 allegations of exploitation o 1 confirmed o 2 unconfirmed. According to a list provided by the facility, there were 155 other investigations of serious incidents not involving abuse, neglect, or exploitation. This included: • 16 serious injuries/determined cause, • 7 serious injuries from peer-to-peer aggression, • 0 serious injury/undetermined cause • 7 sexual incidents, • 9 sexual incident-offender, • 4 choking incident, • 14 suicide threats, • 6 encounters with law enforcement, • 19 unauthorized departures, • 1 death, and • 72 other (unknown). From all investigations since 46/1/13 reported by the facility, 30 investigations were selected for review. The 30 comprised two 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 (22 cases). • Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS (8 cases). Metric 2.a.1: Based on the Monitoring Teams' review of DADS revised policies, including Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy #002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements. Metric 2.a.2: According to MSSLC Protection from Harm Policy, staff were required to report abuse, neglect, and exploitation immediately by calling the DFPS 800 number. This was consistent with the Settlement Agreement requirements. Metric 2.a.3: With regard to unusual/serious incidents, the facility's Incident Management Policy required staff to report unusual/serious incidents within one hour. The process for staff to report such incidents required staff to follow reporting	

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		requirements detailed on the Exhibit B – Unusual Incidents Reporting Matrix. This policy was consistent with the Settlement Agreement requirements. Metric 2.a.4: Based on responses to questions about reporting, six of six (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Metric 2.a.5: Based on responses to questions about reporting, six of six (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents. Based on a review of the 22 investigation reports included in Sample #D.1: • Metric 2.a.6: 22 (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to DFPS within one hour of the incident or discovery of the incident as required by DADS/Facility policy. Eleven incidents were not reported within one hour of the incident, however, there was no evidence that the facility suspected abuse, neglect, or exploitation prior to the report being filed. • Metric 2.a.7: Seventeen (77%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. o 19 of 22 (86%) indicated the facility director or designee was notified of the incident within one hour. ▪ DFPS notified the facility of allegations of emotional/verbal abuse and physical abuse in case #42922198 at 6:17 pm on 11/2/13. The director was notified at 9:26 pm. ▪ The UIR for case #42860301 did not document notification of the director. ▪ DFPS notified the facility of an allegation of neglect at 6:17 pm on 11/21/13. The AOD was notified at 8:00 pm and the director was notified at 9:47 pm on 11/21/13. o 22 of 22 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. o 20 of 22 (91%) documented that the state office was notified as required. ▪ In DFPS cases #42914554 and #42897845, the UIR did not contain documentation of state office notification. • Metric 2.a.8: For the allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, 0 UIRs (0%) included recommendations for corrective actions.	

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		Based on a review of seven investigation reports included in Sample #D.2: • Metric 2.a.9: Eight (100%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. • Metric 2.a.10: Eight (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. • Metric 2.a.11: For the unusual/serious incidents for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, _____ UIRs/investigation folders (____%) included recommendations for corrective actions. (N/A: all were reported as required by state policy) Metric 2.a.12: The facility had a standardized reporting format. 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. Metric 2.a.13 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. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. Forty-six of 46 (100%) new employees hired between 10/1/13 and 11/21/13 signed this form when hired. All employees were required to sign an acknowledgement form annually. A random sample of 24 employees at the facility was chosen. Twenty-four of 24 employees (100%) in the sample signed this form annually as required by state policy. The facility was in non compliance with the requirements of D2a. The facility should ensure that all required notifications are documented in the facility incident report.	
	(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 5/1/13 and 11/7/13. The log included the applicable investigation case number, date of the incident, any disciplinary actions taken, and the date the employee was returned to work.	Substantial Compliance

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	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 22 investigation reports included in Sample D.1, in 19 out of 19 cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status immediately. In 19 out of 19 cases (100%), where there was a known alleged perpetrator, 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 22 investigation files in Sample D.1, 22 (100%) UIRs documented additional protections implemented following the incident. This typically consisted of placing the AP in a position of no client contact, a head-to-toe assessment by a nurse, and changes in level of supervision when applicable. All allegations were discussed in the daily IMRT meeting and protections were reviewed. Based on the facility's actions to remove staff from duty pending the investigation, and documenting additional actions to protect the alleged victims in all cases, the monitoring team found that the facility was in substantial compliance.	
	(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 four 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. • 19 of the 19 (84%) employees with current training who had been employed over one year had completed the ABU0100 refresher training within 12 months of the 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. • 19 of the 19 (68%) employees with current training who had been employed over one year had completed the UNU0100 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on this review, the facility was in substantial compliance with the requirement for annual training.	
	(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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Metric 2.i.1: The facility policy and/or procedures defined sufficient procedures to audit whether significant injuries are reported for investigation. Metric 2.i.2: The facility conducted audits at least semi-annually, during the preceding 13 months. Ten files were chosen to be audited monthly. Fifty-two record audit reviews were reviewed by the monitoring team. In these 52 reviews, no significant injuries were discovered that were not reported for investigation. Metric 2.i.3: The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation. Auditors reviewed Integrated Progress Notes, Staff Observation Notes and Shift Logs, Client Injury Data Reports, Unit Meeting Minutes, and Campus Coordinator Logs for documentation of any injuries the individual might have incurred during the month reviewed. The auditor then looked for a corresponding injury report or investigation if the injury was from an unknown source or in an unusual (suspicious) location on the body. Staff were required to notify the facility director and DFPS of injuries of unknown origin where probable cause cannot be determined and to DADS Regulatory if the injury was deemed serious.	Substantial Compliance

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		The facility: • Reviewed all reported injuries at the morning unit meetings and any serious injuries at the daily IMRT meeting. • Quarterly data reports were compiled to identify trends in injuries. As noted in D4, injury trends were not being adequately addressed by the facility. Sample #D2 included investigations completed on a sample of six serious injuries. All six investigations were completed by the facility. The facility investigator investigated all serious injuries. Findings were reviewed by the facility at daily IMRT meetings. 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. Metric 2.i.4: In _____ of _____ (n/a) cases in sample #D.2, significant injuries identified by the audit that had not previously been investigated were reported to the Facility Director, and/or DFPS, as appropriate and immediately investigated. (none found)	
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	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	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.		
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	<u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Investigations included in sample #D.1 noted the date and time of initial contact with the alleged victim. (The three investigations referred back to the facility for further review were not used in this sample). o Contact with the alleged victim occurred within 24 hours in 14 of 19 (74%) investigations. Exceptions were DFPS cases #42924707, #42897845, #42822525, #42787076, and #4242789299. Documentation showed 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. • For investigation in sample #D.1, 11 of 19 (58%) were completed within 10 calendar days of the incident. Extensions were filled for eight investigations. The investigations not completed within 10 days: o Case #42905414 was submitted on the 14th day (witnesses not available for interview). o Case #42903796 was submitted on the 15th day (witnesses not available	Substantial Compliance

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		for interview). o Case #42875987 was submitted on the 16th day (witness not available for interview.) o Case #42860301 was submitted on the 20th day (additional interviews needed). o Case #42852106 was submitted on the 20th day (additional allegations added, additional witnesses to be interviewed). o Case #42822525 was submitted on the 13th day (additional time needed for video review and identification of witnesses). o Case #42787076 was submitted on the 17th day (witnesses were not available for interview). o Case #42789299 was submitted on the 30th day (additional time needed to review video footage, witness not available for interview). • All 22 (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 19 of 22 (86%) DFPS investigations reviewed in Sample #D.1, concerns or recommendations for corrective action were included. Three of those cases resulted in a referral back to the facility for further investigation. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.2: • The investigation began within 24 hours of being reported in eight of eight cases (100%). • Eight of eight (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Three of four (75%) included appropriate recommendations for follow-up action to address the incident. o UIR #2422 was the investigation of a serious injury due to peer-to-peer aggression. At 4:15 pm on the day of the incident, the victim told the facility investigator that he "feared for his life" at his home. The home supervisor notified the individual's QIDP regarding concerns for his safety. The individual was told to go back to his home and the IDT would discuss it the next day. According to the investigation, a peer entered the victim's room while he was in bed that night and hit him in the nose and face. When the victim went to take his bloody sheets to the laundry room minutes later, the peer attacked him again while staff	

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		assigned to supervise the aggressor completed paperwork. The investigator noted that there were no concerns or recommendations in the case. The victim was moved to a different home for the evening when he returned from the emergency room, but future protections were not discussed. Given that the facility failed to protect the individual from the two documented attacks in the investigation, protections should have been put in place to prevent a reoccurrence.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	Metric 3.f.1: Based on the Monitoring Teams' 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. Metric 3.f.2: 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 #D.1: • Metric 3.f.3: In 21 out of 22 investigations reviewed (95%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. o The investigator for DFPS case #42942707 concluded that the allegations against the two named APs were unconfirmed because it was not possible to prove that the two named staff were responsible for the AV at the time of the incident. The finding should have been inconclusive rather than unconfirmed since the evidence did not rule out neglect by the named APs. • The report utilized a standardized format that set forth explicitly and separately: o Metric 3.f.4: In 22 (100%), each unusual/serious incident or allegations of wrongdoing; o Metric 3.f.5: In 22 (100%), the name(s) of all witnesses; o Metric 3.f.6: In 22 (100%), the name(s) of all alleged victims and perpetrators; o Metric 3.f.7: In 22 (100%), the names of all persons interviewed during the investigation; o Metric 3.f.8: In 22 (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 Metric 3.f.9: In 22 (100%), all documents reviewed during the investigation; o Metric 3.f.10: In 22 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving	Substantial Compliance

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		the alleged victim(s) and perpetrator(s) known to the investigating agency; o Metric 3.f.11: In 22 (100%), the investigator's findings; and o Metric 3.f.12: In 22 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Metric 3.f.13: In seven out of eight investigations reviewed (88%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. o For UIR #2445 the investigator determined probable cause for a serious discovered injury was an incident of peer-to-peer aggression that occurred on 9/23/13. The injury was discovered when the individual complained of pain on 9/25/13. He was sent to the emergency room where it was determined that he had a broken rib. The investigation focused on the events from 9/23/13, though there was no evidence presented in the UIR that the individual was in pain prior to 9/25/13. The investigator did not interview possible witnesses or view surveillance video to rule out other probable causes. • The report utilized a standardized format that set forth explicitly and separately: o Metric 3.f.14: In eight (100%), each unusual/serious incident or allegations of wrongdoing; o Metric 3.f.15: In eight (100%), the name(s) of all witnesses; o Metric 3.f.16: In eight (100%), the name(s) of all alleged victims and perpetrators; o Metric 3.f.17: In eight (100%), the names of all persons interviewed during the investigation; o Metric 3.f.18: In eight (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o Metric 3.f.19: In seven (88%), all documents reviewed during the investigation; ▪ UIR #2445 indicated that the investigator would review video footage of an incident suspected to be the cause of a serious injury. The UIR did not include a summary of that review. o Metric 3.f.20: In eight (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o Metric 3.f.21: In eight (100%), the investigator's findings; and	

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		o Metric 3.f.22: In eight (100%), the investigator's reasons for his/her conclusions.	
	(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.	Metric 2.g.1: 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. Metric 2.g.2: The facility policy required that any further inquiries or deficiencies be addressed promptly. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Metric 2.g.3: The DFPS investigations in Sample D.1 met at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) <u>and</u> D.3.f . • Metric 2.g.4: The facility Incident Management Review Team (IMRT) requested a methodological review for one investigation in the sample. The facility did not agree with the finding of a confirmed allegation of physical abuse in DFPS case #42706605. DFPS reopened the case for further investigation. DFPS upheld the confirmation in the case. • Metric 2.g.5: For two of the DFPS investigation files the monitoring team noted problems with regard to sections D.3.e, and/or D.3.f. Based on a review of the facility's IMRT data, for none (0%), the facility IMRT correctly noted the problems with the investigation and/or report, and returned the investigation to DFPS for reconsideration. • Metric 2.g.6: The facility returned one case in the sample to DFPS for reconsideration, for one (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. The IMC reported that cases were routinely returned to DFPS when the facility did not agree with findings or had further concerns. 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, • 22 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 18 (82%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. o DFPS case #42914554 was completed by DFPS on 11/6/13. The UIR was signed off on by the IMC and facility director designee on 11/18/13.	Noncompliance

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		o DFPS case #42875987 was completed by DFPS on 10/8/13. The UIR was signed off on by the IMC and facility director designee on 10/17/13. o DFPS case #42840486 was completed by DPFS on 8/28/13. The UIR was signed off on by the IMC and facility director designee on 9/6/13. o DFPS case #42787076 was completed by DFPS on 7/11/13. The facility review form noted that the final report was received by the facility on 7/15/13. The IMC and facility director designee's UIR review is dated 6/26/13. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Metric 2.g.7: In eight out of eight investigation files reviewed (100%), 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. • Metric 2.g.8: The supervisor did not identify concerns in any of the cases. For these investigations, for ___ (n/a), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. • Metric 2.g.9: For the one investigation noted above for which the monitoring team identified deficiencies, the supervisory review did not appear to address these deficiencies. The facility was not in substantial compliance with the requirement for prompt 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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such	Metric 3.i.1: 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. Metric 3.i.2: The policy and procedures did not specify the facility system for tracking and documenting such actions and the corresponding outcomes. The facility continued to track follow-up to recommendations in the daily IMRT meeting minutes. The meeting minutes included a date that recommended action was completed, but no evidence that a	Noncompliance

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	actions and the corresponding outcomes.	review was completed to ensure protections were effective and/or continued to be implemented. A subsample of investigations was reviewed to confirm that appropriate disciplinary and/or programmatic action was taken following the investigation when warranted. This sample included a total of seven cases: • Four DFPS cases: #42952106, #42840486, #42787076, #42837323; and • Two facility investigations: UIR #2571 and #2445 Metric 3.i.3: For four out of four of the DFPS investigations and one of one facility investigation reviewed in which disciplinary action was warranted (100%), prompt and adequate disciplinary action had been taken and documented. Based on a review of a subsample of investigations (listed above) for which recommendations for programmatic action were made, the following was found: Metric 3.i.4: For three out of five of the investigations reviewed (60%), prompt and thorough programmatic action had been taken and documented when recommended by DFPS or the facility investigator. The exceptions were: • DFPS investigation #42952106 included concerns/recommendations for programmatic action resulting from the investigation, including inadequate supervision, missing documentation, and a broken video camera. The facility UIR assigned the unit director to address all concerns. The investigation file did not include evidence that the concerns had been addressed. • UIR #2445 was the investigation of a serious injury due to peer to peer aggression. The IDT met and recommended that he be moved to a different home for his future safety. The investigator did not include this recommendation in the UIR or make recommendations for his safety until the move could be completed. The UIR included a recommendation for evaluation by habilitation therapies for a mothercare spoon to reduce his risk for choking. The therapist completing the evaluation noted that he refused to use the spoon but staff would be trained on encouraging him to use it. The outcome of this plan was not documented. Metric 3.i.5: For zero out of seven 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 track outcomes from investigations.	

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		Based on identified issues with the documentation and tracking of recommendations and desired outcomes, the facility remained out of compliance with this provision.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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.	Metric 4.1: 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: • Metric 4.2: Were conducted at least quarterly; • Metric 4.3: Did address the minimum data elements; • Metric 4.4: Did use appropriate trend analysis procedures; • Metric 4.5: Did provide a narrative description/explanation of the results and conclusions; and • Metric 4.6: Did contain recommendations for corrective actions. Metric 4.7: Based on a review of trend reports, IMRT minutes, and QAQI Council minutes, when a negative pattern or trend was identified, corrective action plans were not always developed. Injury trending reports identified seven individuals with three or more serious injuries for FY13. Metric 4.8: As appropriate, corrective action plans were not developed both for specific individuals and at a systemic level. • The trend report showed that Individual #589 had five serious injuries during FY13. Trend information was provided to his IDT prior to his annual team meeting. His ISP indicated that the IDT reviewed the injuries, but did not	Noncompliance

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		develop a plan to reduce his injuries. His IRRF did not identify that he was at risk for injury. • Individual #466 had three serious injuries. His IDT met several times each month between June 2013 and October 2013. His injuries were reviewed during ISPA meetings, but no recommendations were made to attempt to reduce his risk for injury. • Individual #157 had three serious injuries. His IDT noted a significant trend of injuries at his annual team meeting. His ISP documented the IDT review of trend data for 30 injuries and agreed to look for ways to reduce his injuries and incidents. Documentation did not indicate that the team continued to review trends to determine if supports were effective at reducing injuries. Unit meeting minutes indicated that many injuries at the facility were the result of peer-to-peer aggression. It was not evident that the facility was addressing the trend of peer-to-peer aggression through the development of corrective action plans. A sample of unit meeting minutes for three units (Shamrock, Whiterock, and Barnett) was reviewed to determine if the facility was adequately addressing the trend of peer-to-peer aggression. Longhorn meeting minutes did not document discussion of peer-to-peer aggression for the time periods reviewed. Trends were not reviewed or addressed in the unit meeting minutes, IMRT meeting minutes, or facility trend reports. The following incidents were noted in the three units reviewed 10/14/13 through 10/20/13 and 9/12/13 through 9/19/13. • 10/20/13- Individual #510 was punched in the back by another individual as he exited his room. • 10/19/13 – Individual #592 sustained a contusion to the eye when another individual hit him. • 10/17/13 – Individual #157 was attacked by a peer causing an abrasion and redness to his rib area and left deltoid. • 10/17/13 – Individual #15 was slapped by another individual. • 10/14/13 – Individual #125 sustained a fractured nose when multiple peers hit him and kicked him. • 10/13/13 – Individual #192 sustained injuries to his left ear when another individual hit him in the head with a phone. • 9/20/13 – Individual #475 was slapped by a peer. • 9/20/13 – Individual #568 was scratched on the neck by a peer. • 9/18/13 – Individual #460 was kicked between the legs by another individual. • 9/15/13 – Individual #261 sustained a fractured finger in an altercation with another individual. • 9/14/13- Individual #15 sustained a nasal fracture and an orbital fracture in an altercation with another individual.	

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		• 9/12/13 – Individual #227 was kicked by another individual. • 9/12/13 – Individual #279 was kicked on two separate incidents by another individual. • 9/12/13 – Individual #595 was hit by another individual. Metric 4.9: The trend reports and minutes did not show that corrective action plans were implemented and tracked to completion. When trends were identified, the incident management department made general recommendations to investigate the trend further. A status update was included the following quarter in the trend analysis. Metric 4.10: The report/minutes reviewed, as appropriate, the effectiveness of previous corrective actions. Based on a review of resulting action plans included in quarterly trend reports and documentation related to implementation: Quarterly trend reports did not include action plans with specific outcomes related to trends identified. General recommendations for action were included in the quarterly QAQI Council presentations. • Metric 4.11: Zero action plans (i.e., there were no action plans) included in the quarterly trend report (0%) described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness. • Metric 4.12: For zero of the action plans reviewed (0%), the plan had been timely and thoroughly implemented. • Metric 4.13: For zero action plans (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. To move forward, the facility will need to ensure that as trends are identified, 1. Measurable outcomes and action steps are developed; o The monitoring team recommends ensuring that unit directors are involved in the identification of trends, in the development of action plans, and in the implementation and reporting of actions. 2. Specific staff are assigned to monitor and document implementation; and 3. A date is set to review efficacy of the plan and make revisions when needed.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.		

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:** <u>Documents Reviewed</u>: o DADS policy #003.1: Quality Enhancement, dated 1/26/12, updated 5/22/13 with new DADS administrative staff names o MSSLC facility-specific policies (no changes since last review): • Quality Assurance Adm-37 4/1/12 • Participating in PIT Monthly Meeting CC-42 5/29/13 • Participating in PET Monthly Meeting CC-36 4/25/12 • QAQI Council o MSSLC organizational chart, November 2013 o MSSLC policy lists, October 2013 o List of typical meetings that occurred at MSSLC, undated but likely November 2013 o MSSLC Self-Assessment, 11/25/13 o MSSLC Action Plans, 11/25/13 o MSSLC Provision Action Information, 11/20/13 o MSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 12/9/13 o QA director's worksheet based upon the last monitoring report, undated o MSSLC DADS regulatory review reports, June 2013-October 2013 o List of all QA department staff and their responsibilities, undated, likely October 2013 o MSSLC QA department meeting notes, monthly June 2013 to October 2013 (4 meetings) o MSSLC data listing/inventory, hard copy, 11/15/13 o MSSLC QA plan narrative, undated o MSSLC QA plan matrix, 11/15/13 o MSSLC QA data list matrix combined document, 11/15/13 o QAQI Council presentation schedule o Set of blank tools used by QA department staff (1) o Sets of completed tools used by QA department staff (none) o Sets of graphs of the QA department's one tool o Trend analysis report, for three of four components, last two quarters, (only 1 quarter submitted) o 3 sets of other data (staff injuries, criminal activity, suggestion box) o Blank campus coordinator monitoring form o Monthly QAD-SAC-1:1 meetings (no documentation) o Unit morning meetings, 5 days, week of 12/9/13, all five units o Unit PIT meetings, minutes and various handouts, monthly, June 2013-October 2013 (5) o PET I, II, and III meetings, minutes and handouts, June 2013-November 2013 (6) o PET II agenda and handouts for 12/11/13 meeting o MSSLC QA Reports, monthly, 6/6/13 through 12/12/13 (10)

	o QAQI Council minutes, at least monthly June 2013 to November 2013 (6 months, 9 meetings) • Handouts and agenda for meeting during onsite review, 12/12/13 o PIT, PET, work group reports (none provided) o MSSLC Corrective Action Plan documents • 7 CAP implementation and tracking forms • CAP tracking sheet, November 2013 (contains 10 CAPs) o DADS SSLC family satisfaction survey, 5 respondents, July 2013 o Individuals satisfaction survey, 60 respondent, October 2013 o Community/business satisfaction survey (none) o Staff satisfaction survey (none) o List of self-advocacy leadership 2013 o Self-advocacy monthly meeting minutes/notes, monthly May 2013 to September 2013, two meetings per month o Home meetings with individuals, agenda and notes, last two from each home, October 2013 o Facility newsletters, The Family Press, Focus, and weekly activity bulletins. <u>Interviews and Meetings Held</u>: o Kim Kirgan, Director of Quality Assurance, Stormy Kimbriel, QA program monitor 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 5 campus coordinators, 2-10 shift o Joy Lovelace, Human Rights Officer <u>Observations Conducted</u>: o Unit morning meetings, Longhorn, Shamrock, Whiterock o PET II monthly meeting, 12/11/13 o QAQI Council meeting, 12/12/13 o Executive management, 12/10/13 o Self-advocacy meeting, 12/10/13 o Clinical services meeting, each morning
	Facility Self-Assessment The self-assessment had some additions and edits compared to the previous self-assessment. These changes put the self-assessment more in line with what the monitoring team examines during the compliance reviews. In conducting future self-assessments, the results would benefit if the criterion used by the QA director was similar to that used by the monitoring team. For example, in E1, the self-assessment notes that the data inventory list was updated and includes all data being collected. The monitoring team also looks for the data list inventory is missing anything that should have been included. The self-assessment looked at

	whether the QA plan was present; the monitoring team also looks at whether it was updated if needed. On the other hand, the self-assessment correctly noted that the QA matrix was in need of updating to include self-monitoring and key indicators. Regarding CAPs, the self-assessment appeared to indicate that more activity was occurring with CAPs than the monitoring team was able to discern from the available QA department CAPs documentation. The QA director's rationales for the self-ratings for all 5 provisions were reasonable. 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 continued to make progress. There was not yet a complete and adequate data list inventory at the facility. Twenty of the 20 provisions (100%) were included. Of these, 16 (80%) included data that could be used to identify trends as required in the wording of section E1; 11 (55%) included a wide range of data; 13 (65%) included what appeared to be key indicators; 0 (0%) described the data being collected; and 15 (75%) included a self-monitoring tool (or indicated that a self-monitoring tool was not used because of the extensiveness of the data, i.e., C and K). The MSSLC QA plan matrix was not well organized and the items did not line up with the data listing inventory, the QA reports, and the content presented to the QAQI Council. There were items in the QA plan matrix for 20 of the 20 sections (100%), however, a set of key indicators was not specified. MSSLC had other sets of data that were not incorporated into the QA program (i.e., not on a data listing inventory, not presented in a QA report or to QAQI Council), such as vandalism, confiscation of weapons, criminal activity, follow-ups to ISPAs, and the various data that were part of the unit directors' PIT meetings. Data from 19 of the 20 (95%) sections of the Settlement Agreement were summarized and graphed showing trends over time (all but section E), but only some (9 of 20 [45%], C, D, F, O, P, Q, R, S, V) analyzed data (or presented data in any way) across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals. Unit daily morning meetings were now to include the QA function of the now-discontinued unit PIT meetings. The monitoring team attended morning meetings in three of the five units and reviewed minutes and handouts for all five units. The monitoring team did not see how the QA functions of data review, trending, and creating action plans were yet occurring within this meeting. Monthly PET meetings continued in the same manner as described in previous reports. There were three PET groups, the SAC facilitated every meeting, and the QA director attended as an active participant. At the PET meetings, data were presented and there was some discussion among participants.

	A facility QA report was created for six of the last six months (100%). There was little narrative analysis done in the report. The best examples were sections M, D, and V. The QAQI Council met at least once each month. During the meeting observed by the monitoring team, there was a lot of participation and discussion for section D, and some for section J, but little during section L. It might be that attendees did not know what should or could be included for section L (medical), whereas everyone was highly involved with, trained in, and aware of section D (ANE, incidents, injuries). The facility and QA director were still working on establishing an organized CAPs system. The QA director had a CAPs tracking sheet, which was updated at the end of each month, and which indicated that there were 10 CAPs; 4 of the 10 new were since the last review. An adequate written description did not exist that indicated how CAPs were generated, including the criteria for the development of a CAP. The sample of 4 CAPs appeared to have been implemented (100%). The monitoring team, however, could not determine that all aspects of CAPs were implemented fully and in a timely manner. There was not yet an adequate system for tracking the status of CAPs.

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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.	Policies 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, #003.1: Quality Assurance, dated 1/26/12. The monitoring team's comments on the state policy are in the previous monitoring report and are not repeated here. Also, given that the statewide policy was disseminated almost two years ago, edits may be needed. State office should consider this. There were no 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 a facility specific policy because, once complete, it should detail much of the facility specific QA activity. Further, given that a number of changes had occurred in the operation of the QA program at MSSLC, many of the facility policies needed to be further updated, eliminated, or created. For instance, unit level PITs no longer existed, yet the policy was still active. Their function was now expected to be part of the each unit's daily morning meeting. A policy would be helpful for this.	Noncompliance

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		There were no data reporting on whether all facility staff were trained on the QA policies and practices at the facility. This seemed particularly important given the many new QIDPs and QIDP coordinator. <u>QA Department</u> 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. In many of these meetings (e.g., PET, QAQI Council), she asked questions and made comments regarding QA practices for the presenting department. The QA director continued to hold one staff meeting per month. She reported that she would be moving to meeting every other month. Given the close proximity of their offices, and their frequent interactions with one another, this seemed reasonable. <u>Quality Assurance Data List/Inventory</u> There was not yet a complete and adequate data list inventory at the facility. The data list inventory was 23 pages long, contained 23 topic areas (some were not Settlement Agreement related), and was managed in an excel spreadsheet. Twenty of the 20 provisions of the Settlement Agreement (100%) were included. This was great to see. Sections C and K; O, P, and R; and G, H, and L were combined into single list inventories. Of the 20 inventories, 16 (80%) included data that could be used to identify trends as required in the wording of section E1; 11 (55%) included a wide range of data; 13 (65%) included what appeared to be key indicators; 0 (0%) described the data being collected; and 15 (75%) included a self-monitoring tool (or indicated that a self-monitoring tool was not used because of the extensiveness of the data, i.e., C and K). For instance, in section F, the reader could not tell what was being measured for the item "QA of ISP," such as whether this was a quality measure of the entire ISP document and its assessments, of the meeting held by the IDT, or some other aspect. For the G-H-L list, it was unclear what was meant by the data item "Medical services," whether any external medical audits were included, and why some N and J items were included. In general, the section L tool, should be the medical department's quality program (i.e., section L3). The facility, however, recently began a process to improve the data listing inventories. Each inventory was now reviewed every quarter. This was done by having the section leader present it during his or her PET presentation and then at the subsequent QAQI Council meeting. The monitoring team observed this occur during the onsite review. Some relevant discussion occurred, especially regarding the avoidance of duplicating data collection, such as between the psychology and nursing departments. The	

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		discussion was led by the QA director. The monitoring team suggests that she focus upon ensuring that the content is complete, items are described adequately, and that the data are being directed to the categories in the Settlement Agreement's wording of section E1. This is important to do because MSSLC was no longer conducting QAD-SAC 1:1 meetings. Each data list inventory contained two columns indicating if the data were to be presented in the QA report and/or to QAQI Council. Since everything in the QA report is presented to QAQI Council there is no need to have a duplicated column. Instead, the monitoring team recommends that there be one column to indicate if the data are to be presented in PET and a second column to indicate if the data are to be presented in the QA report/QAQI Council. If neither column is checked, it would thereby indicate that the data are maintained by the department, but are not presented to PET or in the QA Report or to QAQI Council. The data list inventory was, however, current. Each list was noted to have been updated on 11/15/13. That is, even though more work was needed on the content, a review and update date within the last six months was included for each section. The QA director should put the update date for each list separately, when they're reviewed and updated by the department head and QAQI Council. It is unlikely that all 20 were reviewed and updated on the same date. <u>Quality Assurance Plan Narrative</u> The QA plan narrative at the facility was slightly modified since the last review, but was not current, complete, and adequate. It was four pages long and contained all of the sections recommended in the previous report, however, the content of each of these sections did not fully reflect current practice and expectations for the QA program at MSSLC. For instance, it included a paragraph about PITs, but they no longer existed. Instead, the role of unit morning meetings should be described. A new subsection was added into the Quality Assurance Indicators section. It described three categories of indicators: key, clinical, and business/structural. This was a reasonable way to think about indicators and may help section leaders to develop a more comprehensive set of indicators, however, it was not being implemented at all, not in the data listing inventories, QA matrix, PET meetings, QAQI Council, etc. The two sample tables in the narrative were updated to show the forms that the QA director was now using. The MSSLC QA program could be conceptualized as consisting of at the two following levels. The direct service level needs to be incorporated into the QA program, such as having a data list inventory, QA matrix, a QA report, and a QAQI Council presentation. All	

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		of this should be described in the QA plan narrative. • Section/department level (i.e., data list inventory, QA matrix, PET presentations, QA report, and QAQI Council presentation, and • Direct service level (i.e., unit level PITs, now being replaced by unit level morning meetings). As noted above, the QA plan narrative, once improved and finalized, might be considered to be a facility-specific policy. <u>QA Plan Matrix</u> The QA plan matrix should contain the data from the data list inventory that are to be submitted to the QA department; these data are then included in the QA reports and presented to the QAQI Council. MSSLC had a QA plan matrix. The monitoring team reviewed the November 2013 QA matrix. The MSSLC QA plan matrix was just past five pages long. It was not well organized and the items did not line up with the data listing inventory, the QA reports, and the content presented to the QAQI Council. The QA plan matrix was almost identical to the QA plan matrix described in previous reports. The only difference was that, in this iteration, the QA director combined the implementation of monitoring tools done by different people (e.g., QIDP coordinator, QIDP facilitators, QA staff) into a single line with a sub-section for each of these people. Also, some items were added (e.g., CPR drills, evacuation drills) and some were deleted (e.g., ANE, injury). Overall, the facility was not using the QA matrix as it was intended, that is, to be a subset of the data listing, such that it correctly showed which data were to be presented in the QA report and to QAQI Council along with more detail on how the data were to be collected, reviewed, and managed. There were items in the QA plan matrix for 20 of the 20 sections (100%). However, for the 20 sections of the Settlement Agreement, a set of key indicators was included for N/A of the 20 (N/A%). A rating of whether these items were key important indicators was not made by the monitoring team because it was clear that the facility and the department heads did not create the QA matrix to guide and describe the important key indicators for each section. Instead, it contained, almost solely, self-monitoring tools, some of which did not exist or were not being used (see below). Of the 20, both process and outcome indicators were identified for N/A of the 20 (N/A%) in the QA matrix. The contents of the data listing inventories and key indicator lists contained both process and outcome indicators, however, due to the disparity across the data listing, QA matrix, QA report, and QAQI Council presentations, the monitoring team did not score this metric.	

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		Similarly, of the 20, in N/A (N/A%), the indicators provided 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 director should describe, for each section, possibly in the notes from the PET meetings, or in her own notes, how data were being collected and presented to identify trends across the variables described in the wording of E1. The QA matrix did not include all self-monitoring tools/self-monitoring procedures. It should include the self-monitoring tools used for each of the 20 sections of the Settlement Agreement (or indicate that a self-monitoring tool was not necessary along with a rationale). The QA matrix listed self-monitoring tools for 17 of the 20 sections (85%). The data listing inventory, however, for 5 of these 17 (29%, C, K, E, G, and H) did not include an item labeled as a self-monitoring or self-assessment tool, thus, calling into question the validity of what was on the QA matrix. Others were not considered to be useful (i.e., valid) by section leaders, such as those for section T. All data that QA staff members collected were listed in the matrix (at MSSLC, this was the one QA department tool). The interobserver agreement activities that QA staff were to collect were also included. This tool contained 23 items and was revised to 27 items, and vastly improved, in August 2013 and October 2013. All satisfaction surveys were not included in the QA matrix. Individual and family surveys were included, but not any of the others. • An individual satisfaction survey was implemented and responses from 60 individuals were presented. Same as during the last onsite review, the results were overall positive, but there were some areas in which follow-up was called for, but did not appear to have been done. • The results of the family survey were only for five families in the past six months, solely from the Martin and Longhorn units. The small number of responses was not explained. • There was no community business satisfaction survey • There was no staff satisfaction survey. • Self-advocacy activities can be one way of obtaining satisfaction information from individuals. The self-advocacy group, however, continued to struggle with attendance, participation, curriculum, and focus. • Weekly home meetings were another way of trying to assess satisfaction, but these too were not used for that purpose.	

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		The QA matrix is really a subset of the larger data list/inventory. Therefore, all items in the QA matrix should also be in the data list inventory. As noted above, the QA matrix, data listing inventory, and QA report were not yet lined up properly. This may be a good task for the QAD and SAC to work on together. Further, the QA director and section leaders needlessly spent time creating a document called the Individual Data List Matrix. In this, they attempted to apply the detail required for the QA matrix items to all of the items in the data list inventory. This was not necessary and competed with their ability to get done the more important task of making the QA matrix an accurate document. <u>Other data sets</u>: MSSLC had other sets of data that did not appear to be incorporated into the QA program (i.e., not on a data listing inventory, not presented in a QA report or to QAQI Council), such as vandalism, confiscation of weapons, criminal activity, follow-ups to ISPAs, and the various data that were part of the unit directors' PIT meetings. By incorporating these data into the QA program, and reviewing them regularly, problems are more likely to be identified and actions taken to address them, especially given the changing demographics of the individuals who live at MSSLC. Further, given the amount of data that were reviewed at PIT meetings (and were to now be incorporated into the unit daily morning meetings), it was surprising that this information was not part of the QA program. <u>QA Plan Implementation</u> Items in the QA plan matrix should be implemented as written, submitted, and reviewed. Given that the QA matrix was not yet a functional/useable tool, the following three metrics could not be rated. For the next review, after creating a functional/useable tool, 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 (e.g., at least once each quarter). 2. Reviewed or analyzed by the QA department and/or the department section leader. 3. Conducted as per the schedule. All three items can be determined during a facility's monthly QAD-SAC 1:1 meetings. At MSSLC, however, these meetings were discontinued. The QA director reported that she would be attempting to use the PET meetings to do what she would have done during 1:1 meetings.	

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		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 the facility: 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. o The MSSLC self-assessment reported that the content was valid for 19 of the 20 sections (all but E), but did not say how this was determined. 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 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. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The QAD and SAC need to ensure that the content of the data inventories are comprehensive and do not omit any important indicators. A plan to do so should be created, implemented, and reported on at the next onsite review. 2. Ensure the items in the QA matrix represent those process and outcome indicators that are most relevant to the section, and that they track data to identify trends as per the wording of this provision E1.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s)	Data from 19 of the 20 (95%) sections of the Settlement Agreement were summarized and graphed showing trends over time (all but section E), but only some (9 of 20 [45%], C, D, F, O, P, Q, R, S, V) analyzed data (or presented data in any way) across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals. To make this determination, the monitoring team reviewed the PET meeting handouts and minutes for the past three months September 2013 to November 2013, QA reports for six months June 2013 through November 2013, and QAQI Council minutes for those same six months.	Noncompliance

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	responsible; and the time frame in which each action step must occur.	Monthly QAD-SAC meeting with discipline departments The facility had begun to hold these meetings at the time of the previous review. In the intervening six months, however, the facility made a determination to discontinue these 1:1 meetings and instead use the PET meetings to accomplish what would have been done at these meetings. That being said, there was no documentation, notes, agenda, or minutes available for any 1:1 meetings that had been held. There was no documentation (within the PET meeting minutes or QA director notes) to indicate that this was being done in PET meetings. In order to accomplish the typical goals of the 1:1 meetings, the QA director will need to ensure that the many topics of a QAD-SAC 1:1 meeting are covered during the PET meetings. These are QA-related activities, including but not limited to review of data list inventory, updating of QA matrix, data summarizing, data graphing, data analysis, and corrective action planning and monitoring. Thus, given this change, the monitoring team was unable to rate the following metrics, but will do so in future reviews based upon examination of the performance and documentation of the three PETs, and any other documentation provided by the QA director. 1. Since the last onsite review, a meeting occurred at least twice for xx of the xx (xx%) sampled sections of the Settlement Agreement. 1a. All five topics below were conducted during xx of the xx (xx%) meetings that occurred. • 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 xx of the xx (xx%) meetings, data were available to facilitate department/discipline analysis of data. 3. Since the last onsite review, during xx of the xx (xx%) meetings, data were reviewed and analyzed. 4. Since the last onsite review, during xx of the xx (xx%) meetings, action plans and/or CAPs were created for systemic problems and for individual problems, as identified; or an indication was noted that a corrective action plan was not needed.	

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		<u>Other QA-Related Meetings</u> Unit level monthly PIT meetings: These continued for most of the previous six months, but were now discontinued. Unit daily morning meetings: The QA function of these meetings (i.e., replacing the monthly PIT meetings) had only begun in late November 2013. The monitoring team attended morning meetings in three of the five units and reviewed minutes and handouts for all five units for the week of 12/2/13. • The monitoring team did not see how the QA functions of data review, trending, and creating action plans were yet occurring within this meeting. o There was some PIT documentation in the Barnett minutes (for master teachers) and in the Martin minutes (for nursing). • The unit directors told the monitoring team that recent information was kept at the top of the meeting and that the bottom was for historical information. They said that this change in meeting focus was working for them, that graphing wasn't all that useful, and that much of what was in the PIT was being presented and reviewed in other forums, such as QAQI Council. o The monitoring team suggests that the unit directors and their unit morning meetings be incorporated into the facility QA program, including having a data list inventory, matrix, QA report section, and quarterly QAQI Council presentation. Monthly PET meetings: These continued in the same manner as described in previous reports. There were three PET groups, the SAC facilitated every meeting, and the QA director attended as an active participant. • At the PET meetings, data were presented and there was some discussion among participants. • Occasionally, topics from PETs were brought to QAQI Council, though this was not seen in QAQI Council meeting minutes since 7/25/13. • The SAC and QA director made general announcements at the start of the meeting regarding QA-, Settlement Agreement-, and Settlement Agreement monitoring team-related topics. • The meetings were organized and their format was consistent across the three PETs and from month to month. • A next step is for more thorough analyses of data, rather than merely reporting the data. o Good examples were the presentations by the nursing staff for section M, and the psychology department's reported analysis that found a correlation between moves between homes and restraints.	

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		QA Report 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%). The content of the QA reports lined up with the presentations to be made at QAQI Council. In other words, there was one QA report for each QAQI Council meeting, that is, sometimes one in a month, sometimes two. Of the 20 sections of the Settlement Agreement, 14 (70%) appeared in a QA report at least once each quarter in the last six months. The other 6 (30%) appeared in one of the two quarters. Of the 34 sections of the Settlement Agreement that were presented quarterly, (0%) contained all of the components listed below. On the other hand, all 34 contained at least some of the components listed below, usually the presentation of some self-monitoring data and other key/important indicators. • 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 Additional comments regarding the QA reports are below: • The section E report should include data on QA activities. • There was little narrative analysis done in the report. The best examples were sections M, D, and V. There were improvements for sections G, H, N, J, and Q. • The one set of data collected by the QA department was not reported anywhere, not even within the section E presentation. • There was no presentation or analysis of the data regarding staff injuries due to individual behaviors, criminal activity, and the suggestion box comments. QAQI Council 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 the monthly QAQI Council meetings from the end of June 2013 through the end of December 2013 (9 meetings).	

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		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, including presentation of Settlement Agreement sections in an organized, scheduled manner. 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 (indicators, self-monitoring) were presented (though the QA matrix was not yet accurate, see above), and (b) the data presented were trended over time. There was little indication (0%), however, that (c) comments and interpretation/analysis of data were presented. • Some sections included comment and interpretation, most notably for sections D and M. Minutes from 0 (0%) QAQI Council meetings since the last review reflected if recommendations and/or action plans were discussed, suggested, or agreed to during each portion of the meeting. • In the minutes, only a single word (e.g., reviewed, completed) was written to describe the section presentations. There was nothing about what was discussed (except for a sentence for N on 10/10/13 and Q on 11/14/13). • Because so much importance is placed upon the QAQI Council and QA report, the QAQI Council minutes should more accurately reflect discussion, concerns, actions to be taken, etc. • Section M included an update on CAPs for their section. This was good to see. During one QAQI Council meeting observed by the monitoring team, there was active participation of participants other than the presenter for all (40%) of the reports/data presented during the meeting. • During the meeting observed by the monitoring team, there was a lot of participation and discussion for section D, and some for section J, but little during section L. It might be that attendees did not know what should or could be included for section L (medical), whereas everyone was highly involved with, trained in, and aware of section D content (ANE, incidents, injuries). o This was an area where the QA director can take the lead to ensure that the data listing and matrix are comprehensive and that attendees have	

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		the information they need in order to participate. Work Groups/Performance Improvement Teams There were various other committees and work groups that presented in the QA report and QAQI Council. The QA director should ensure that this information is also located within the appropriate section within the data list inventory and QA matrix. Corrective Actions Further work was done to improve the corrective action system, though the facility and QA director were still working on establishing an organized CAPs system. At the time of this review, the QA director had a CAPs tracking sheet, which was updated at the end of each month, and which indicated that there were 10 CAPs; 4 of the 10 new were since the last review. The QA director said that none of the previous 6 CAPs was yet closed. In addition, 3 new CAPs were created and approved during the onsite review for a total of 13. Because the latest 3 were just approved, their dissemination and implementation had not yet occurred, therefore, they were not included in this compliance review. Each of the CAPs had a two page CAP Implementation/Monitoring form completed. Each form had a list of a number of actions/steps that comprised the corrective action 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. • It appeared, however, that some training and discussion activities had occurred during QAQI Council meetings regarding CAPs. One was on 7/25/13; the topic was the definition of a CAP and how a CAP differed from an action plan. The minutes said there was a presentation, but the monitoring team did not receive any reports, handouts, or descriptions of what was presented and what effects the training/discussion might have had since that date. The other was on 8/22/13; in which the QA director was noted to report that every section should have one or more CAPs and that this facility would likely have 20-25 CAPs. Again, no further information was provided regarding the discussion or its effects. Of the 4 CAPs reviewed by the monitoring team (i.e., the CAPs implemented since the last review), 4 (100%) appeared to appropriately address the specific problem for which they were created.	

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		Based on these 4 CAPs: • 4 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. • 1 (25%) included the anticipated outcome of each action step. o Moreover, there were no specific criteria to judge if the overall CAP was met, or if progress had occurred (0%). This was a serious problem in the CAPs program. Because the criterion was never specified, the reader cannot determine if the actions met the problem for which they were designed. o Six of the previous CAPs had not yet been completed. • 4 (100%) included the job title of the person(s) responsible, however, only 2 CAPs (50%) included the name of the person responsible. • 3 (75%) included the time frame in which each action step must occur (i.e., a due date). At MSSLC, the entire CAPs management documentation was via a spreadsheet. Thus, the wording of the issue/reason, actions, outcomes, responsible persons, and target dates must be held to a very high standard by the QA department. The spreadsheet did not contain much information about the status of CAPs. The nursing department reported on their CAPs during their PET and QAQI Council presentations, but the information should also be summarized in the CAPs management system. As noted in section L2, the medical department reported that action plans based on their external reviews had not been developed. This was different than the QA department's report that 100% of 96 action plans were conducted and completed. The QA director should explore this.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the CAPs tracking document of a sample of 4 CAPs: • 0 (0%) included documentation about how the CAP was disseminated • 0 (0%) included documentation of when each CAP was disseminated, and • 0 (0%) included documentation of to whom it was disseminated, including the names of the specific persons responsible. All 4, listed only the title of the person to whom it was disseminated, on the spreadsheet.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired	The sample of 4 CAPs appeared to have been implemented (100%). This was based upon content of presentations at the many meetings attended by the monitoring team, not based upon an organized tracking method managed by the QA department.	Noncompliance

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	outcome of remedying or reducing the problems originally identified.	The monitoring team, however, could not determine that all aspects of CAPs were implemented fully and in a timely manner. To address this, the QAD might indicate status on the spreadsheet and include as one of the items in the PET meeting minutes. That is, for each CAP, indicate whether it was implemented in a timely manner, done fully, and modified if needed (this last variable is for section E5). When a CAP, and all of its actions, are completed within the target due date, the reader can infer that it was implemented fully and timely. For those not yet completed, however, the reader cannot determine whether it was implemented fully and timely. There was not yet an adequate system for tracking the status of CAPs. Of the 4 CAPs being tracked by the facility (via the spreadsheet), 0 (0%) indicated the status of the CAP and any action taken if a CAP had not been implemented. The QA director had a CAP Implementation and Monitoring form for each CAP. The information in it was useful and relevant for the design of the CAP, but it did not seem that it would be used for the ongoing monitoring and review of the CAP. The facility QA director did not maintain summary information/data regarding CAPs and their status (regarding pending/open or closed) that was updated within the month prior to the onsite review. The QA director had a spreadsheet, but it did not contain much information, especially regarding implementation, and she did not maintain documentation of those CAPs that were open versus those that were completed/closed (this may because no CAPs were yet completed/closed). The QA director or section leader did not present this information to QAQI Council at least quarterly. The monitoring team has recommended that the QA director maintain and graph some simple data on CAPs/action plans. These data can be part of the section E data list inventory and possibly the QA matrix, too.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The QA director did not review CAPs each month with the responsible person/section leader. There was not, however, a way or place to document if the CAPs were effective, especially for CAPs that were completed/closed. That is, whether the CAP successfully addressed the problem for which it was created, not only that the action steps were implemented. The monitoring team will be looking for: • Evaluation of the effectiveness of CAPs, including outcomes	Noncompliance

#	Provision	Assessment of Status	Compliance
		• CAPs are modified when needed. • Modifications/results are discussed at QAQI Council. • Modifications are implemented as written fully and timely.	

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 Corrective action plans to address audit findings o Monitoring tool used to assess the quality of the ISP and the ISP meeting o List of all QIDPs and assigned caseload o A list of QIDPs deemed competent in meeting facilitation o Data summary report on assessments submitted prior to annual ISP meetings o Data summary report on team member participation at annual meetings. 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 #105 and Individual #160 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #595, Individual #466, Individual #578, Individual #508, Individual #574, Individual #157, Individual #504, Individual #881, Individual #98, Individual #329, Individual #347, Individual #300, Individual #130, Individual #927, Individual #231, Individual #951, Individual #139, Individual #589, and Individual #225 <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, psychologists, and QIDPs in homes and day programs o Ramona Echols, Acting QIDP Director o Carla Wilkins QIDP Educator o Melinda High, ISP Facilitator o Laura Gore, ISP Facilitator o Patrick Samuels, Incident Management Coordinator o Charlotte Kimmel, PhD, Director of Psychology o Don Morton, ADOP o Joy Lovelace, Human Rights Officer <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 12/9/13

	o Performance Evaluation Team Meeting II – 12/11/13 o Restraint Reduction Committee Meeting – 12/12/13 o Annual IDT Meeting for Individual #105 and Individual #160 o Pre-ISP Meeting for Individual #505 o Shamrock (S-5) ISPA meeting for three individuals
	Facility Self-Assessment: MSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 11/25/13 with recent activities and assessment outcomes. The Acting QIDP Director was responsible for the section F self-assessment. MSSLC continued to use the statewide section F monitoring tool to assess compliance with section F, though they were phasing it out and replacing it with new tools. 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. These are the same type of activities that the monitoring team looks at to assess compliance. The facility self-rated itself as being out of compliance with all provision items in section F. Findings for provisions that were audited by the facility were similar to findings of the monitoring team. For example, the monitoring team and the facility each found problems with meeting attendance, timely submission of assessments, and ensuring that action plans were developed to address assessment recommendations.
	Summary of Monitor's Assessment There was progress evident with the ISP process. At two ISP meetings, one pre-ISP meeting, and one ISPA meeting observed by the monitoring team, significant progress was observed towards: • Integrating the risk identification process into the ISP process. At the ISPs observed, the risk discussion was much more integrated into the discussion regarding the individual's preferences, daily schedule, and support needs. • All disciplines working together to develop specific supports during annual team meetings. IDTs observed were moving in a positive direction. It was not evident, however, that meetings were resulting in the development of a comprehensive ISP that incorporated all recommendations and needed supports. To move forward towards compliance with the many provisions in section F, the monitoring team recommends a focus on the following activities during the next six months: • All departments need to ensure that assessments are completed at least 10 days prior to the annual IDT meeting and are available to all team members for review. • The facility needs to track submission of assessment by discipline prior to the annual ISP meeting and address any trends of late submission with the specific department responsible for submission. • IDTs need to develop measurable outcomes and implementation strategies that will allow for

	consistent implementation and data collection. • Outcomes should be developed based on each individual's known preferences that encourage greater exposure to a variety of activities (particularly in the community) and lead towards the acquisition of new skills based on known preferences and needs. • 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. Likewise, data collected regarding incidents, injuries, and illnesses should be used to alert the IDT that supports are either not being implemented or are not effective and should be revised.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed two ISP meetings, one pre-ISP meetings, and three ISPAs. The ISP facilitator facilitated the annual IDT meetings. IDT meetings observed were good examples of facilitation that ensured that team members participated in the meeting. Participation by all team members present was encouraged. In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, ISPAs, PSIs, Rights Assessments, Integrated Risk Rating Forms, Integrated Health Care Plans and/or risk action plans, CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, the last six QIDP monthly reviews, individual's daily schedule, Special Considerations list, and ISP Preparation Meeting documentation as available. A sample was requested of the most recently developed ISPs from each residence on campus, and eight were submitted for review. The packets submitted for Individual #518 and Individual #574 did not include the updated ISP. Therefore, only six recent plans were submitted for full review. A variety of QIDPs and interdisciplinary teams (IDTs) responsible for the development of the plans were sampled. The facility used the statewide Q Construction Facilitation Training in conjunction with a competency tool used to assess competency in facilitation skills. Twelve of 23 (52%) QIDPs had been deemed competent in regards to facilitation skills via this tool.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was used to assist the ISP facilitators in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QIDPs used this template to draft portions of the ISP prior to the meeting. The ISP facilitators 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 QIDP at the annual IDT meeting. QIDPs were in attendance at all annual meetings in the sample reviewed. QIDPs remained responsible for monitoring and revision of the ISP. As noted throughout this report, the monitoring team found the QIDPs did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed. While the facility was in substantial compliance with the requirement that one person on the IDT facilitate development of an ISP, 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 or when outcomes had been completed. To move forward, the facility needs to focus on ensuring that all QIDPs are competent in meeting facilitation skills. Then, ensure that QIDPs are monitoring progress/regression and revising supports and services when needed. The facility will need to demonstrate that QIDPs were taking action when the monthly review process or other data note a lack of implementation, change in status, or a lack of progress.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	DADS Policy #004.1 described the Interdisciplinary Team (IDT) as including the individual, the Legally Authorized Representative (LAR), if any, the QIDP, 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 pre-ISP process to identify assessments to be completed prior to the annual ISP meeting. The facility, however, was not consistently using the ISP Preparation Meeting to identify team members for participation in the ISP meetings. The form that should have been used to identify team members required to attend the annual ISP meeting was being used as a signature sheet to show which team members attended the ISP Preparation Meeting.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility was tracking data on attendance at IDT meetings. Data were not collected for attendance by all relevant team members. The table below is a summary of data gathered by the facility in regards to attendance at annual ISP meetings for June 2013-September 2013.	

Team member	Attendance by relevant team members	Percentage
Individual	115/126	91%
Family/Advocate	No data	
LAR	No data	
Dental services	No data	
Dietician	9/12	75%
Direct Support Professionals	118/126	94%
Home Supervisor	No data	
ISD	No data	
Local Authority	No data	
Habilitation Therapies	109/111	98%
Pharmacy Services	No data	
Primary Care Provider	17/17	100%
Psychiatrist	6/8	75%
Psychologist/Behavior Analyst	112/112	100%
Nursing Services	126/126	100%
Speech Therapist	No data	
Vocational Services	126/126	100%

Review of a sample of ISP attendance sheets confirmed that there were key staff missing who were identified as relevant participants in three of four (75%) of the annual meetings in the sample. The sample included Individual #231, Individual #130, Individual #300, and Individual #121.

- At the annual ISP meeting for Individual #231, all relevant team members were in attendance or there was evidence that the team had adequate input prior to the ISP meeting.
- Individual #130's family did not attend the meeting in person or by phone, though the ISP indicates that they were active advocates on his behalf. Work was listed as a priority for him. Vocational staff did not attend his meeting. His psychiatrist was also absent from the meeting.
- Individual #300's family did not attend in person or by phone. The ISP noted that his family advocated for him and visited regularly. He was routinely seen by the psychiatrist for multiple psychiatric diagnoses and medication management. The psychiatrist did not attend his annual ISP meeting.

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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At the annual IDT meeting for Individual #121, there was no participation by his dietician or psychiatrist.
In the monitoring team's review of provisions O, P, and R, SLPs attended over 90% of the meetings, but OT/PT clinician attendance was more inconsistent

In a related issue, psychiatry staff indicated that they did not feel welcome at the ISP meetings. This is an issue that must be addressed between leadership of the various disciplines (e.g., psychiatry, QIDP, psychology). It is imperative that psychiatry is an active part of the ISP process and attends the ISP meetings, not only upon invitation, but as part of the IDT.

The facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process. Relevant team members should be identified at the pre-ISP meeting, then the facility should use that information to track actual attendance by relevant team members at the ISP meeting.
</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 #004.1 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 were presented as a total for all disciplines. By presenting the data this way, the facility could not identify which disciplines were not submitting assessments prior to the ISP meeting. Data gathered regarding the submission of assessments from 6/1/13 through 9/31/13 indicated that assessments were not routinely submitted prior to ISP planning meetings. The chart below shows assessment submission rates for that time period.

<table>
<tr><th>Month</th><th>Submitted 10 days prior to the ISP meeting</th><th>Late</th><th>Not submitted</th></tr>
<tr><td>June 2013</td><td>472 (74%)</td><td>152 (24%)</td><td>10 (2%)</td></tr>
<tr><td>July 2013</td><td>381 (69%)</td><td>162 (29%)</td><td>8 (1%)</td></tr>
<tr><td>August 2013</td><td>527 (69%)</td><td>219 (29%)</td><td>15 (2%)</td></tr>
<tr><td>September 2013</td><td>445 (72%)</td><td>119 (19%)</td><td>54 (9%)</td></tr>
</table>

The facility self-assessment indicated an overall increase in the timely submission of assessments prior to the ISP meeting from 57% to 71%. The time period for the compliance percentages was not identified.
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. The sample included Individual #300, Individual #951, Individual #231, Individual #130, Individual #121, and Individual #518. Zero (0%) of six individuals had all assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. The following table represents findings by discipline from that review.	

Assessment	Submission Rate
Medical	100%
Audiology	0%
Dental	0%
Nutritional	50%
OT/PT	100%
Speech	50%
Nursing	100%
Pharmacy	0%
Day Programming	None requested
Psychiatry	100%
Psychology	80%
Vocational	0%
Functional Assessment	33%

The facility continued to utilize the Functional Skill Assessment (FSA) to identify priority training. As noted above, the assessment was not always completed prior to the annual ISP meeting. As noted in previous reports and in section S of this report, the FSA was, by itself, not adequate for capturing this information and for guiding training priorities. Interpretation and analysis of the FSA is required for it to be a useful assessment. 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 list of preferences and strengths for each individual was fairly comprehensive and appeared to be based on assessment information.

The facility was not yet in compliance with this item based on the data available. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months

#	Provision	Assessment of Status	Compliance
		1. 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. 2. Data regarding the submission of assessment prior to the ISP meeting should be discipline specific in order for the facility to focus corrective action on departments that consistently show low assessment submission rates.	
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 always done in time for IDT members to review each other's assessments prior to the ISP meeting. There had, however, been progress made in integrating assessment recommendations into support plans when available to the team. QIDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and then information from assessments is used to develop plans that integrate all supports and services needed by the individual. The facility was not yet in compliance with this provision. To move forward, QIDPs will need to ensure that assessments are completed prior to the annual ISP meeting and all recommendations from assessments are used to develop and revise supports as needed.	Noncompliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	DADS policy mandated that a Living Options discussion 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. As part of the ISP process, each discipline was now required by state policy to include, as part of the pre-ISP assessment process, an explicit determination of whether or not needed supports could be provided in a less restrictive setting and whether the individual should be referred for transition. Assessments in the sample generally included a statement regarding whether or not supports could be provided in the community. In the new ISP format, 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. See section T regarding the quality of discipline specific determinations. At annual ISPs observed for Individual #160 and Individual #105, team members discussed providing supports in a less restrictive environment. Both teams engaged in discussion regarding what supports would be needed in a community setting and any barriers to living in the community. Both ISP facilitators asked for recommendations from all team members regarding optimal placement.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #160's family attended the meeting and were very outspoken regarding their wishes for her to remain at the facility. Team members acknowledged that supports could be provided in the community, but were hesitant to make a recommendation for community placement. The team ultimately determined that her current placement was the best place for her. The LA did not attend the meeting, by request of the family. The ISP facilitator was respectful of the family's decision while offering to provide information on other placement options if the family was interested in learning more about community options in the future. • At Individual #105's IDT meeting, the IDT engaged in a thorough discussion regarding optimal placement and the supports that he would need in the community. Good discussion was observed regarding community options and optimal supports with consideration given of his preferences. The LA was present at the meeting and able to offer necessary information to the team regarding placement options. The team stopped short of developing a specific action plan with timelines for completion. There was little focus on providing additional opportunities for individuals to participate in day programming in the community. The facility did not have options for individuals to receive day habilitation in the community. Minimal formal training was occurring in the community. Nine ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #121, Individual #951, Individual #589, Individual #225, Individual #100, Individual #139, Individual #300, Individual #130, and Individual #231. One (11%) of the ISPs included meaningful training opportunities in the community. Community based outcomes for most individuals in the sample consisted of generic opportunities to visit in the community with little or no opportunity for training or meaningful integration. For example: • Individual #121 had community based outcomes to "attend community events that he enjoys at least two times per month" and "pick any community activity that he would like at least four times a month." The outcome did not describe specific training to be provided in the community. • Individual #951 had outcomes to attend community trips and to visit community group homes over the next year. ISPs that included specific measurable training objectives to be implemented in the community: • Individual #589 had an outcome to utilize the public library in the community.	

#	Provision	Assessment of Status	Compliance
		There was no focus on providing supported employment or volunteer opportunities for individuals at the facility. The sheltered workshop should be a job training site with a goal to support individuals to work in the community. The vocational program provided minimal training focused on community employment. None of the ISPs in the sample included outcomes developed to increase opportunities to explore job opportunities in integrated work environments.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	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 engaged in a much better discussion of support needs in relation to preferences. The teams reviewed the list of preferences developed during the pre-ISP meeting, and developed plans to include the individual's preferences throughout the day. Risks were discussed in relation to the individual's preferences and interests. The team stopped short of using preferences to build training opportunities. Lists of preferences included a broad range of activities and were individual specific. IDTs, however, 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. Preferences were used to develop outcomes for participation in preferred activities, but training was not based on preferences in the ISPs reviewed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 specific interests, or exploring volunteer or work opportunities. In a review of nine recent ISPs, one (11%) offered specific training to be provided in the community. While the community was often listed as a possible training site for outcomes, training was not designed specifically for functional training in the community. As noted in F1e, outcomes for training offered opportunities for visits in the community, but few were focused on gaining specific skills. IDTs did little to develop community integration strategies that included the use of community settings to teach skills that would support successful community living or integrate preferences identified by and for the individual into SAPs. To move in the direction of substantial compliance, the monitoring team recommends that the facility focus on developing outcomes to address barriers to service and supports being provided in a less restrictive setting.	
	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;	A sample of ISPs, IHCPs, 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. Little progress had been made in the development of measurable outcomes. The monitoring team found that there were still many outcomes not written in a way that staff could measure progress towards completion or plans did not provide enough information to ensure consistent implementation. None (0%) of the plans in the sample included a full array of measurable outcomes. For example: • Individual #300 had an outcome to increase his independent living in the next 12 months. Objectives included "will write/state all the one and two letter sight words." Instructions were not clear on which words he would need to learn or what would be considered a successful attempt. Another objective for money management stated that he would combine coins and bills to equal a purchase price between ___ dollars to buy specified items. Again, there was not enough information to ensure consistent implementation. • Individual #231 had a SAP to address communication skills. The instructions were not written in a way that staff could determine what would be a successful attempt towards completion of this outcome. • Individual #121 had an objective to address his risk for weight gain in his IHCP.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The objective stated that he would adhere to diet and get more exercise. The IHCP did not describe his diet or exercise program to ensure consistent implementation. • Individual #139 had a service objective to attend church services in the community at least monthly. No information was documented regarding his preference of churches, type or time of service that he preferred to attend, or supports needed. Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. Sections M and 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.	
	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. 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. As noted in F1d, the facility did not have an adequate system in place for ensuring that assessment information was integrated into the ISP. 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 IHCP. The facility had made progress in developing comprehensive ISPs that integrated all supports and services. However, as noted throughout section F, assessment information was often not available prior to the ISP meeting. Further, it was not evident that recommendations from assessments obtained after the annual ISP meeting were integrated into the ISP.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. Observation at two annual ISP meetings indicated IDTs were making considerable progress towards integrating protections, services, and supports into one comprehensive plan. In the past, each discipline would report independently on each particular assessment/plan related to their own discipline. IDTs now were holding a much more integrated discussion and all discipline representatives appeared comfortable discussing supports in each area. For example, each discipline contributed to the discussion regarding Individual #160's communication skills. It is expected that progress will continue to be made in developing comprehensive plans as IDTs become more adept at developing both functional and 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 or criteria for monitoring effectiveness of intervention. <u>Time frame for completion</u> A sample of ISPs were reviewed to verify that outcomes included a time frame for completion. All (100%) included projected completion dates. In all cases, the date was an annual date rather than a date based on the individual's expected rate of learning or projected need for specific supports. <u>Staff responsible</u> SAPs and IHCPs in the sample included designation of which staff /discipline would be responsible for implementation of the outcome and which staff would monitor the plan. The one exception where this information was not found was in Individual #121's IHCP. It did not include the person responsible for implementing or monitoring the plan.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. 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. None of the ISPs in the sample included adequate outcomes for functional participation or integration in the community. For example, there were few outcomes to shop in the community for food to prepare a meal, complete transactions at a community bank, pick up prescriptions at the pharmacy, seek membership at a gym or library, or take a community art or fitness class. As noted throughout section F, there was very little measurable training occurring in the day habilitation programs. Vocational outcomes were not found that would develop vocational skills needed for community employment. 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. To move forward, 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.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the	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 Health Care Plans included similar information.	Noncompliance

#	Provision	Assessment of Status	Compliance
	objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	The type of data to be collected and the frequency of implementation were to be in 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 now included the person responsible for data collection and the person responsible for review of that data. IDTs will need to develop outcomes that are measurable in order to permit objective analysis of the individual's progress.	
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. When assessments were recommended by the team, it was not evident that the ISP was revised to include recommendations once the assessment was completed. To move forward, the facility will need to ensure that recommendations from various assessments are available to all members of the IDT prior to the annual ISP meeting, and then are 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 10 out of 12 (83%) records reviewed, however, only five (41%) included a current IHCP, which should be considered an integral part of the ISP. The facility reported that all (100%) of ISPs were filed within 30 days of development over the past six months. From the sample of eight ISPs submitted to the monitoring team for review of section F, six (75%) were current. The facility needs to ensure that all plans are accessible and comprehensible to staff assigned to implement the plan and staff can clearly communicate what supports should be provided and what data should be gathered. As noted above, outcomes and action steps were not always written clearly enough to ensure consistent implementation and data collection. 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

#	Provision	Assessment of Status	Compliance
		To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. All outcomes should be written in clear, measurable terms. 2. ISPs should be accessible to staff within 30 days of the development of the plan.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	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. QIDPs were responsible for reviewing the overall plan. The facility had a QIDP monthly review process to review all supports and services. It was not evident that an adequate review process was in place to ensure that the review of supports and services led to timely implementation of assessments or changes in supports when necessary. An adequate review process was not in place for any of the ISPs in the sample. For example, • The QIDP monthly review of services for July 2013 for Individual #951 indicated that data showed 100% successful trials for four of his outcomes. Criteria for successful completion were set at 88%. The QIDP recommended continuing training with no changes recommended. • The QIDP monthly review for Individual #589 for 4/16/13 through 5/15/13 was completed on 7/30/13, more than two months after data were collected. The QIDP monthly review for 5/16/13 through 6/16/13 was not completed until 8/2/13. His health care plans were listed under the health services review section. The QIDP did not summarize data collected in regards to his IHCPs in either review. The monthly review indicated that no data were available for review of his individual counseling or implementation of his PBSP for the July or August review. • The QIDP monthly review of services for May 2013 and June 2013 for Individual #130 was not completed until 9/16/13. His annual ISP meeting was held 8/8/13. Information from the monthly review would not have been available for consideration by the IDT at his annual meeting. Review of his vocational outcomes indicated that data were no longer available for review for either month. • The July 2013 and August 2013 monthly reviews for Individual #300 noted no data were available for review regarding his PBSP and STARS program. His IHCP objectives were listed, however, no data were included to indicate that the effectiveness of his IHCPs were reviewed. As discussed in section D of this report, the facility needs to review trends of incidents and injuries and revise supports and protections when current supports are not effective	Noncompliance

#	Provision	Assessment of Status	Compliance
		for keeping individuals safe. ISP facilitators were entering information on trends of incidents and injuries into the draft ISP, however, it was not yet evident that IDTs were effectively using this information to develop or revise supports. As the facility continues to progress toward developing person-centered plans for all individuals at the facility, QIDPs need to keep in mind that ISPs should be a working document that will guide staff in providing supports to individuals with changing needs. To move forward towards compliance, 1. QIDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues or consider revising supports. 2. Plans should be updated and modified as individuals gain skills or experience regression in any area.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised	In order to meet the Settlement Agreement requirements with regard to competency based training, QIDPs 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. QIDPs 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. Staff instructions for many plans did not offer enough information to ensure consistent implementation or did not include recommended support strategies from assessments. Informal interviews throughout the facility indicated that staff were generally able to describe supports and services developed through the ISP process. A review of data collected regarding implementation indicated that data were often missing or the status of outcomes could not be determined. See comments regarding the monthly review process in F2d. To move forward, the facility will need to ensure that plans are available and training on new or revised supports occurs within 30 days of development.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 10 (83%) of 12 individual notebooks in the sample, however, IHCPs were not available to staff in seven of 12 records. The monitoring team requested a list of ISP dates with the date the ISP was due, the date the meeting was held, and the date the ISP was filed (document V.10). Data provided by the facility indicated that while all ISP meetings were held within 365 days of the previous ISP meeting. Further, the facility reported that all ISPs developed in the past year were filed within 30 days after the annual ISP was held. Two of the eight ISPs in the sample submitted to the monitoring team, however, were over 365 days old. Although, it appeared that the IDT had met within 365 days, the new ISP was not submitted.	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. Quality assurance activities with regards to ISPs were not fully developed or implemented (also see section E above). The facility had just begun to analyze findings and develop corrective action plans based on self-assessment findings. Progress had been made towards developing an effective quality assurance system to identify problems with the ISP and implementation, though this process had not been in place long enough to determine the effectiveness of the process.	Noncompliance

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, a limited number of activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. For provision G1, there were 3 items listed: (1) attendance at the clinical services meeting, (2) attendance at the annual ISP meetings and (3) tracking of issues discussed at the clinical services meeting. Compliance scores for the first two items were consistently over 90% for most disciplines. The third item had a score of 76%. The facility rated itself in noncompliance for provision item G1. For provision G2, facility staff (1) reviewed one consultation report from each unit monthly from 4/1/13 - 9/30/13 to ensure Interdisciplinary Team (IDT) teams were made aware of the physicians' acceptance or denial of recommendations from outside consultations and (2) reviewed all non-facility consults from 4/1/13 - 9/30/13 to ensure tracking log reflected receipt and dissemination to units for review by the Primary Care Physicians (PCP). Compliance scores were 100% and 93%, respectively. While the

	compliance scores were for both areas were excellent, the metrics did not reflect the requirements of the Settlement Agreement and state policy. Those requirements are discussed in G2. The self-assessment may include any items that the facility desires to include, however, as stated in previous reports, the self-assessment should include the items reviewed by the monitoring team. Failure to do so will likely result in an erroneous self-rating. In moving forward, it is important for the medical director to review this report, the comments, and the recommendations. Future self -assessments should include a variety of activities. The monitoring team does not rely on one specific activity, such as a chart audit, document review, or interview. Rather, the monitoring team utilizes a broad range of information. The facility may self-report data and the monitoring team selects a sample for verification. In some instances, it is necessary to verify all data points. Records are reviewed, staff is interviewed, and observations are conducted. From these activities, the monitoring team determines a rating of substantial compliance or noncompliance based on defined criteria. To that end, the facility's self-assessment should not be based on a single type of activity. Each provision item likely has more than a single metric that must be evaluated to determine a compliance rating. The facility found itself in noncompliance with provision G1 and substantial compliance with G2. The monitoring team found the facility to be in noncompliance with both provision items.
	Summary of Monitor's Assessment: Throughout the conduct of the review, the monitoring team found some evidence of integration of clinical services. No true progress was appreciated. There were no new major initiatives specifically related to the integration of clinical services. The monitoring team had the opportunity to meet with the medical director and medical compliance nurse to discuss integration activities at the facility. There was evidence that integration was occurring, but it was not sufficient and this was acknowledged. There were some areas that were known to be particularly problematic. MSSLC did not have any formal plan, committee, or workgroup established to help move towards substantial compliance in this area. It appeared that the problems that were occurring in some clinical disciplines had never really surfaced to a higher administrative level for resolution. One benefit of having a formal plan for integrating services is that it allows a collaborative forum for discussion of the barriers to integration. The medical director served as the section G lead, but many of the other clinical disciplines were not under his purview. He could, therefore, not resolve some of the issues that needed attention. Throughout the week of the review, the monitoring team encountered several good examples of integrated clinical services. Areas where integration was needed, but failed to be evident were also noted. Continued work in this area is needed. The medical director will need support from facility management to resolve identified barriers to integration. Additional guidance from state office in the form of a finalized policy will also likely provide greater clarity on the next course of action. There was significant improvement on the part of the primary providers in the completion of the IPN entries for outside consultations. This improvement was noted with the implementation of the new IPN

	format in October 2013. Since this was a relatively new process, most records had very few notes in the new format. The monitoring team will need to evaluate this process during the next compliance review.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	MSSLC continued efforts to integrate clinical services. Yet, there were many opportunities for improvement. The facility did not capitalize on these opportunities because there were no efforts directed specifically towards improving integration. That is, there was no overarching plan for the facility to move towards substantial compliance for this very important provision. As evidenced by the self-assessment, there was very little work done in this area to ensure that the clinical disciplines provided seamless and integrated services. Throughout the conduct of the review, the monitoring team unfortunately heard anecdotal accounts of discipline silos that were having a significant and adverse impact on the delivery of services. Those issues need to be addressed to move forward. This was particularly evident with regards to the integration of psychiatrists into the IDT process as psychiatry staff reported a sense of marginalization within the IDT. The monitoring team reviewed local and state procedures, conducted interviews, completed observations of activities, and reviewed records and data to determine compliance with this provision item. During the conduct of this review, many examples of integration of clinical services were observed. The monitoring team observed a variety of activities designed to foster integration of clinical services. These activities included daily meetings, periodic meetings, and committee meetings. Additionally, the monitoring team met with the medical director, who served as lead for sections G and H, and medical compliance nurse to discuss the status of sections G and H. The facility had data related to attendance at the daily clinical services meeting, and ISP attendance. Attendance was good for most required departments based on data submitted. However, in terms of meeting participation, there were a number of other meetings that could have been reviewed, including ISPAs, Pharmacy and Therapeutics Committee, Desensitization Committee, and Infection Control Committee. Data related to participation in neurology and psychiatry clinics would have also been good measures for integration of clinical services With regards to the actual delivery of clinical services, the medical director reviewed several examples of cases, which provided evidence of integration of clinical 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		the psychology director. The events of the past 24 hours were discussed, including hospital admissions, transfers, and use of emergency drugs, medication and clinic refusals, and restraints. • Daily Unit Meetings Committee meetings attended by the monitoring team included: • Pharmacy and Therapeutics Committee • Medication Variance Reduction Committee • Polypharmacy Oversight Committee • Desensitization Committee • Medical Review Committee Details related to the function and activities of these committees are provided throughout the report. The following are some examples of integration based on observations, interviews, and other activities listed above: • The PNMT worked well together for assessment and follow-up with IDT members and medical staff attended a number of the PNMT meetings, or participated by phone as needed. The PNMT RN consistently attended morning medical meetings and PNMT members routinely attended IDT meetings as needed. There were very clear referral guidelines in place to assist the IDTs in recognizing when referral was indicated. Once a referral was generated, the IDT participated routinely during PNMT and ISPA meetings to integrate recommendations into the ISP, IRRF, and IHCP. A weakness appeared to be in collaboration between speech and psychology. The SLPs did not attend the Behavior Support Committee meetings. • The monitoring team attended an Individual Support Plan meeting, which was held to complete individual #331's ISP, IRRF, and IHCP. The individual's direct support professional, relevant clinical services team members, and individual's school support advisor were present during the meeting. Prior to discussing the IRRF and IHCP, a letter was shared from the school system commenting and praising the individual on meeting set goals, which included components from the individuals BSP. The monitoring team was impressed that the team was integrating school, work, and home area when discussing the behavior section of the IRRF. The IRRF and IHCP were reviewed and discussed in terms the individual was able to understand and participate in goal setting. The RN Case Manager did an excellent job in reviewing the individual's health and mental health risk. The RN Case Manager, with each risk, ensured the individual understood what the risk meant and how he could participate in reducing risks.	

#	Provision	Assessment of Status	Compliance
		The RN Case Manager consistently used person-centered language when reviewing and engaging the individual. • Members of the IDT including psychology, nursing, pharmacy, and therapy services were generally present for quarterly psychiatry clinics or other psychiatric clinical consultation. • Medical collaborated with psychiatry and pharmacy to review pretreatment sedation/anesthesia for off campus appointments. • The dental director and the designated LVN continued efforts with the suction toothbrushing program. The LVN provided supervision for the direct care professionals. The PCPs identified those who needed the treatments. • The dental director worked with medical and psychology via the desensitization committee to remove barriers to dental treatment. The monitoring team also noted several areas in which there was a definite lack of integration: • The medical staff continued to have poor participation in the annual ISPs. The data provided to the monitoring team indicated that the primary medical provider attended only 9% of the annual ISPs for the reported period. • Psychiatry attendance at ISPs was 75%. This was only for those ISPs that a psychiatrist was requested to attend. Overall, attendance was very low. For example, there were a total of 183 ISP meetings held between the months of June 2013 and November 2013. The psychiatrist's attendance was requested at eight of the 183 meetings. Psychiatry attended six of these meetings. • Data presented at the QA/QI council indicated issues with timeliness of QPMRs. In September 2013 and October 2013, greater than 90% of the QPMRs were held on time. In the month of November 2013, this dropped to 70%. Overall, the monitoring team saw evidence of integration, but much work was needed. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: • The facility should review the participation of the various disciplines in the ISP process and take appropriate corrective actions to increase participation in the fundamental planning meeting. • Clinical disciplines should track attendance at ISPAs. Medical should particularly track post-hospitalization ISPA attendance since health plans likely change. • The facility should address the issues noted above. • The state should provide additional guidance in the form of a policy.	

#	Provision	Assessment of Status	Compliance
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 tracked consultations with a local database. The state database was not utilized. A total of 40 consults completed after June 2013 was reviewed: • 32 of 40 (80%) 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 Settlement Agreement required that medical providers review and document whether or not to adopt the recommendations and whether to refer the recommendations to the IDT for integration with existing supports. State policy required that an entry be made in the IPN explaining the reason for the consultation and the significance of the results within five working days. The primary care providers were documenting in the IPN a summary of the findings, agreement, or disagreement with the recommendations, and a decision to refer or not to refer to the IDT. For the records included in the record sample, this format was to be implemented in mid October 2013. Thus, it was a relatively new process. The medical staff appeared to adequately comply with the requirement. Consult notes prior to that time did not include all of the requirements of state policy. The majority of consults reviewed occurred prior to October 2013. The self-assessment indicated that all non-facility consults were reviewed and 93% were reaching the units. However, data presented in the QA/QI counsel showed the number of consults reaching the facility was declining. The numbers for the months of September, October, and November 2013 were 87%, 65%, and 43% respectively. This appeared to be a significant concern for the medical staff based on the lengthy discussion that occurred in the Medical Review Committee meeting attended by the monitoring team. It was reported during that meeting that the facility had recently resolved the problem in obtaining consults in a timely manner. While the medical staff were performing as expected in this area at the time of the review, the changes were newly implemented and were therefore only seen in the most recent consults. The monitoring team expects that during the next compliance review, an overwhelming majority of consultation notes will be found in this new format. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance: 1. The medical staff should continue the current practice. 2. The medical director should ensure that systems are in place so that primary providers receive consults in a timely manner.	Noncompliance

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 Policy Minimum Common Elements of Clinical Care, 5/13 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. Most of the activities were various types of audits. Much of the work for this provision remained in development. The types of activities required to assess the provision will hinge of further development of the provisions. The facility found itself in substantial compliance with provisions H2 and H7. Provisions H1, H3, H4, H5, and H6 were found to be in noncompliance. The monitoring team found all seven provision items to be in noncompliance.

	Summary of Monitor's Assessment: The facility made limited progress in this area. The medical director served as lead for this provision. A policy for the minimum common elements of clinical care was approved in May 2013. 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 also no review of any unscheduled/interval assessments. Clinical indicators were developed for osteoporosis, constipation, aspiration pneumonia, and diabetes mellitus. All of the clinical disciplines were required to develop metrics and audit tools for each indicator. The lack of an organized medical quality program resulted in an inability to assimilate this information into a cogent plan for the individual under review. Generally, the lack of a medical quality program was a barrier to movement in this area because much of section H is tied to risk management, medical quality, and the establishment of specific metrics and indicators. At the time of the compliance review, there had been no work done to develop a medical quality program. The state medical services coordinator provided the monitoring team with a copy of a comprehensive set of proposed draft guidelines that addressed each provision item with an operational definition, a method of assessing compliance, action steps for assessing compliance and compliance targets. Overall, this was a reasonable approach and should serve as a valuable source of information for the medical director as the facility moves forward with this provision.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>H1</td><td>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.</td><td>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 <u>each department</u> to have procedures for performing and documenting assessments and evaluations. Furthermore, assessments were to be completed on a scheduled basis, in response to changes in the individual's status, and in accordance with commonly accepted standards of practice.

During discussions with the medical director, he explained that the facility tracked annual assessments and compliance rates were improving. Data for the scheduled monthly assessments are presented in the tables below.

<table>
<tr><td colspan="8">Annual Monthly Assessments
April - September 2013</td></tr>
<tr><td>Medical</td><td>Nursing</td><td>Psychiatry</td><td>Psychology</td><td>Pharmacy</td><td>Nutrition</td><td>Dental</td><td>Habilitation</td></tr>
<tr><td>88</td><td>88</td><td>89</td><td>83</td><td>100</td><td>100</td><td>95</td><td>100</td></tr>
</table>

Quarterly assessments were also tracked. Data for those assessments are summarized</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		below. Quarterly Assessments April - September 2013 Medical: 84 | Nursing: 85 | Psychiatry: 91 | Pharmacy: 100 For most of the assessments, there were various data sets and the data submitted did not adequately define the criteria used to determine compliance with timelines. For example, pharmacy reported 100% compliance with timeliness of QDRRs. This differed from the compliance data submitted for N2. 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 major deficiencies for the 25 AMAs reviewed with regards to timelines. Compliance with timelines was 96%. 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 90% of the records reviewed. As discussed in section L1, this was a significant improvement for the medical department. • Quarterly Drug Regimen Reviews - The compliance for timely completion for the reporting period of months of October 2012 - to March 2013 was 52%. Additional details on the timelines and quality of the QDRRs can be found in Section N2. • Comprehensive Annual Dental Assessments - The overall compliance score was 98%. The quality of the documents continued to improved. • MSSLC provided data that 98% of the individuals receiving psychiatric services had an Appendix B evaluation completed. In addition, for individual's newly admitted to the facility, data indicated that 100% were seen by psychiatry and completed within the appropriate time limits. • Therapy assessments were completed annually for individuals provided direct and indirect supports and services in the format of a Comprehensive Assessment or Assessment of Current Status. These were also completed when a change in status was identified by the IDT, post-hospitalization or by referral for an identified need. The details of actions or consults by the PNMT were inconsistently documented in the IPNs. • As described in other sections of this report, the timeliness of OT/PT and	

#	Provision	Assessment of Status	Compliance
		communication assessments continued to be problematic, though improvement was noted in the last couple of months. There had been limited improvements noted in the content aspect of the OT/PT and communication assessments. • Of the 12 records reviewed, there was some improvement in nursing assessments in response to developments, changes, or monitoring of the individual's health conditions. Documentation of skin integrity problems, for the most part, the assessments was performed on a regular basis. However, for some assessments there was not a care plan. <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-rating of noncompliance. To move in the direction of substantial compliance the facility must monitor all three elements that this provision item addresses: 1. The timelines for completion of scheduled assessments 2. The appropriateness of interval assessments in response to changes in status The quality of all assessments (compliance with accepted standards 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. • Over the course of the visit, the monitoring team observed the psychiatrist relying upon the diagnostic criteria in an effort to appropriately diagnose individuals. Additionally, records reviewed revealed some examples of documentation of specific criteria exhibited by an individual indicating a particular diagnosis. <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-rating.	Substantial Compliance
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.	In order to meet substantial compliance with this provision item, five records were reviewed each month by the medical director to ensure that care was appropriate with regards to acute care, however, there was no standardized tool for doing this nor was their any retrievable data available for review. The section H state draft guidelines indicated that facility staff would utilize the clinical pathways, guidelines, and protocols to govern treatments and interventions as	Noncompliance

#	Provision	Assessment of Status	Compliance
		appropriate. Additionally, the draft guidelines stated that the facility was responsible for providing education and development of the clinical staff with regards to the guidelines and protocols. At the time of the compliance review, MSSLC was continuing to implement state issued guidelines. Determining compliance with a given protocol will require that a measurable standard or metric – clinical indicators be developed. The minimum common elements of clinical care could be applied to many conditions. Some work had been done in this area. The development of clinical indicators is discussed in section H4. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance the facility must monitor a full range of treatments and interventions. Indicators should be developed based on the state protocols and other common medical conditions. The development of clinical guidelines can be an infinite process. Therefore, the facility will need to develop protocols and monitor those conditions determined to have the greatest impact on health status. Conditions that affect many individuals or those that have presented medical management challenges should be considered. Medical audits, hospital and emergency department data as well as the sick call roster have the potential to provide insight on how prioritization should occur.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The proposed section H guidelines stated that the facility would ensure that targeted clinical indicators measure the response to treatment and interventions and data would be monitored to determine the appropriateness of the interventions. The actions steps to achieve this centered on development of clinical indicators by the clinical disciplines for seven acute and chronic health care conditions. The facility had established a list of clinical indicators for osteoporosis, constipation, aspiration pneumonia, and diabetes mellitus. This was a good starting point but indicators were needed for all seven of the conditions identified by state office. The facility would then be poised to develop tools to objectively assess treatment. The determination of the appropriateness and efficacy of medical care must be made by a physician utilizing standardized monitoring tools. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility should continue the ongoing efforts related to development of clinical indicators.	Noncompliance

#	Provision	Assessment of Status	Compliance
		2. Audit tools should be developed, based on clinical indicators, for the identified conditions.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The facility assessed compliance with this provision by looking at timely completion of quarterly and assessments ISP assessments. The proposed section H guidelines indicated that the health status was discussed in the annual ISP and ISPA as identified by the IDT and a plan was developed to address the needs of the individual. Additionally, the facility tracked data in development of the identified health plan. The monitoring team was concerned about the lack of medical involvement in the development of the health plans given the lack of participation in annual ISPs. The facility must monitor both acute changes and chronic long-term disease by linking the current monitoring systems. 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 meetings and other status change meetings • ISPA Process • Medical databases (preventive care, cancer screenings, seizure management) • A medical quality program would be the designated quality program and would report certain data elements to the QA/QI council. With appropriate execution of these systems, an individual's care and monitoring could be assessed across this continuum of activities. However, the monitoring team identified a number of concerns related to current processes and systems: • Risk identification and mitigation continued to present challenges for most disciplines. Medical assessments included only cursory comments related to risk. • Overall, adequate plans of care were lacking in the annual medical assessments. • The primary providers and psychiatrists did not usually participate in the annual ISPs. 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 effective monitoring of health status requires proper	Noncompliance

#	Provision	Assessment of Status	Compliance
		oversight of risk assessment and provision of medical care. This will require a robust medical quality program. Many of the aforementioned processes were not well executed at MSSLC resulting in a system that did not adequately and consistently monitor health status. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The primary medical providers should document through discussion of risk assessment and mitigation. 2. Facility management must address the attendance of the medical staff at ISPs and ISPAs. 3. A medical quality program must be developed.	
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 did a retrospective review for this provision by looking at the self-assessment monitoring tools used for monitoring the IRRFs. The goal was to determine if the appropriate changes were made in risk status, if assessments occurred, and referrals were made. This provision addresses the need to develop systems that have the capacity to identify those issues in a real time. At the time of the compliance review, there was the potential to track some changes via the daily patient care meetings, unit meetings, ISPAs, and other meetings discussed above. Clinical indicators would provide the objective means of assessing the adequacy of the treatments and intervention. Thus, the facility must continue the work of developing a comprehensive list of clinical indicators that will be used to determine when therapeutic outcomes are reached. Many of those will be based on clinical guidelines developed. These indicators will help determine when treatment plans must be altered. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance.	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. This policy had not been finalized at the time of the review. A local policy for the minimum common elements of care was submitted to the QA QI during the week of the previous compliance review. It was approved at the time the review. Compliance Rating and Recommendations The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, a state policy related to Provision H should be developed. MSSLC will need to revise its local policy once a state policy is issued.	Noncompliance

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o 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 individuals 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 who received enteral feeding o List of individuals with chronic and acute 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 Data reports regarding the submission of assessments for IDT review prior to annual ISP meetings 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 #105 and Individual #160 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #595, Individual #466, Individual #578, Individual #508, Individual #574, Individual #157, Individual #504, Individual #881, Individual #98, Individual #329, Individual #347, Individual #300, Individual #130, Individual #927, Individual #231,

	Individual #951, Individual #139, Individual #589, and Individual #225 <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, psychologists, and QIDPs in homes and day programs o Ramona Echols, Acting QIDP Director o Carla Wilkins QIDP Educator o Melinda High, ISP Facilitator o Laura Gore, ISP Facilitator o Patrick Samuels, Incident Management Coordinator o Charlotte Kimmel, PhD, Director of Psychology o Don Morton, ADOP o Joy Lovelace, Human Rights Officer <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 12/9/13 o Performance Evaluation Team Meeting II – 12/11/13 o Restraint Reduction Committee Meeting – 12/12/13 o Annual IDT Meeting for Individual #105 and Individual #160 o Pre-ISP Meeting for Individual #505 o Shamrock (S-5) ISPA meeting for three individuals
	Facility Self-Assessment: MSSLC submitted its self-assessment updated 11/25/13. 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 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 was using the section I Settlement Agreement Monitoring Tool along with other activities similar to the activities that the monitoring team engaged in to assess compliance. The facility self-rated each of the three provision items in section I in noncompliance. The monitoring team agreed.

	Summary of Monitor's Assessment: The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. While good progress had been made on meeting substantial compliance, through an improved understanding of the risk process by IDTs, the facility was not in compliance with the three provisions in section I. The monitoring team observed the risk identification process at two ISP meetings and noted progress made in the risk identification process. At both annual IDT meetings observed, the IDT held an integrated discussion regarding risk levels and supports needed to address risks identified. It was still evident that some important assessment information was not being collected and shared prior to the meeting that could contribute to team's ability to make informed decisions regarding appropriate interventions. Without adequate assessments completed prior to the meeting, it was difficult to make clinical determinations in regards to risks. Teams were not consistently documenting the completion of assessments and resulting recommendations. 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 document when assessments were completed and recommendations were implemented. IHCPs were not found in a majority of individual notebooks reviewed, so staff working directly with individuals did not have access to action plans developed through the ISP process. 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. To move forward with section I: • The facility needs to continue to focus on ensuring that all relevant team members are present for meetings and that assessments are completed prior to the discussion of risks. • 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. • Plans should be implemented immediately when individuals are at risk for harm, and then monitored and tracked for efficacy. When plans are not effective for mitigating risk, IDTs should meet immediately and action plans should be revised.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>I1</td><td>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.</td><td>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 (IHCP) 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. IHCPs were designed to provide a comprehensive plan to be completed annually and updated as needed.

The monitoring team observed two IDT meetings using the new style ISP format and new risk rating forms. Significant progress towards developing an effective process to identify risks was observed in both meetings. IDTs were utilizing the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP). In both meetings, team members appropriately added information to the discussion regarding rationale for each risk rating. Overall, both teams engaged in good discussion and assigned appropriate risk ratings. Action plans were developed to address all medium and high risks. Progress was particularly evident in integrating the risk discussion into the overall discussion of each individual's preferences, strengths, and other support needs.

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. The facility had begun to track submission of assessments by discipline. The submission of assessments was a barrier to accurately identifying risks and support needs for individuals. Data submitted for the Section I QA/QI Report dated 10/10/13 indicated that all disciplines were not routinely completing IRRF assessments prior to annual ISP meetings. The table below shows the percentage of assessments submitted 10 days prior to the risk discussion by discipline for June 2013 through September 2013.

<table>
<tr><td>Discipline</td><td>June</td><td>July</td><td>August</td><td>September</td></tr>
<tr><td>Hab Therapies</td><td>56%</td><td>74%</td><td>83%</td><td>83%</td></tr>
<tr><td>Nursing</td><td>62%</td><td>66%</td><td>83%</td><td>80%</td></tr>
<tr><td>Dental</td><td>94%</td><td>85%</td><td>83%</td><td>87%</td></tr>
<tr><td>Nutritional</td><td>91%</td><td>85%</td><td>64%</td><td>67%</td></tr>
<tr><td>Pharmacy</td><td>38%</td><td>78%</td><td>72%</td><td>90%</td></tr>
<tr><td>Psychology</td><td>47%</td><td>33%</td><td>50%</td><td>43%</td></tr>
<tr><td>Psychiatry</td><td>No data</td><td>37%</td><td>53%</td><td>27%</td></tr>
</table>

A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. The sample included Individual #300, Individual #951, Individual #231, Individual #130, Individual #121, and Individual #518. Zero (0%) of six individuals had all assessment recommended at the pre-ISP meeting completed at least 10 days prior to</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		the meeting. Without current assessment data available, IDTs cannot accurately assess risks. While progress had been made in the risk process, it will be imperative that relevant assessments are submitted prior to the annual IDT meeting and that all recommendations are integrated into the IHCP. Though there had been improvements in using assessment results to assign risk ratings, it was not yet evident that all individuals had accurate risk ratings determined by assessment results. For example, • Individual #300 was considered low risk for cardiac disease. His medical assessment indicated that he had hypertension, hyperlipidemia, and he was a smoker. His IDT rated him at low risk for fractures because he had not had a recent fracture. He had been seen in the emergency room six times for injuries in the six months prior to his ISP meeting. His medical assessment also listed GERD and constipation as current diagnoses. He was rated as low risk for gastrointestinal issues. In order to mitigate risk prior to a significant event or change in status, IDTs should carefully consider all risk indicators and conservatively assign risk ratings with the intent of implementing supports to minimize risks before an adverse outcome or change in status occurs.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The 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 implemented, monitored, and revised when significant changes in individuals' health status and needs occurred. As noted in section F, data were often not consistently reviewed. This raised the question of whether or not IDTs were using data to identify when individuals might have a change of status that would require a change in supports to mitigate risk factors. At the ISP meeting for Individual #105, the IDT reviewed all risk categories. The team included Individual #105 in the discussion to ensure that he knew healthy habits that would lower his risks. For example, the team discussed his risk for constipation. The nurse talked with him about foods that might cause problems and his need to stay hydrated. They talked about his drink preferences and asked for his input. This was good to see. Overall, the IDT engaged in good discussion and used integrated clinical indicators to determine risk ratings. The IDT did discover that they had not followed up on lab work from June 2013 showing that he was anemic. There was no evidence that follow-up was completed in a month as recommended by his physician, thus, the IDT was	Noncompliance

#	Provision	Assessment of Status	Compliance
		unable to establish his risk of anemia. Having an adequate system in place to follow-up on all assessments and review data is an essential part of the risk identification process. The monitoring team also attended the ISP meeting for Individual #160. Her IDT also engaged in integrated discussion regarding her risk. Each risk category was discussed and the team debated her risk ratings based on information available to the team. The team was unable to assign accurate risk ratings in all categories due to missing assessments and clinical data. For example, a swallow study was recommended to assess her aspiration risk. This should have been recommended at her pre-ISP meeting so that assessment information could be presented during the risk discussion. It was also noted that she had multiple episodes of vomiting during the past year. Clinical data regarding these episodes were not available to the team to assist in determining her risk for gastrointestinal risks. Although there were noticeable improvements in the risk discussion, it will be imperative that all information from assessments is available to the IDT prior to the annual IDT meeting. 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. For example, • Individual #231's IDT held an ISPA meeting on 10/21/13 to discuss her change of status following a possible choking incident on 10/19/13. The IDT reviewed her IRRF and IHCP. Her risk ratings for choking and aspiration were changed from medium to high, however, it was not evident that further assessments were completed to verify the change in risk ratings. Her doctor originally ordered a swallowing evaluation following the incident. The IDT determined that the evaluation was not needed because the incident was not an actual choking incident. Supports were not revised when her risk ratings changed. • Individual #518's IRRF and IHCP had not been updated since 11/15/12. At that time, she was considered high risk for skin integrity due to several instances of skin breakdown. She was referred to the PNMT for assessment on 4/4/13 due to a slow healing wound. The IDT met on 5/6/13 to review findings from that assessment. An ISPA indicated that recommendations from that assessment were not implemented by the IDT until 6/7/13. She was seen for wound care due to pressure sores on 5/2/13, 6/5/13, 7/9/13, and 9/18/13. It was not evident that the team met to revise supports in her IHCP even though those supports were not effective in preventing incidents of skin breakdown.	

#	Provision	Assessment of Status	Compliance
		The QIDP monthly review process did not document implementation of action steps included in the IHCP. Thus, it was not possible to determine if assessments were completed or if recommendations from assessments were incorporated into supports and tracked for efficacy. The monitoring team reviewed a sample of assessments from various disciplines to determine whether or not an adequate assessment process was in place to address identified risk. Findings by discipline are summarized below, <u>Nursing</u> Based on a review of 12 records, of which 11 had completed nursing assessments, IRRFs, and IHCPS: Eight of 11 (73%) included sufficient nursing assessments to assist the team in developing appropriate plans sufficient to meet the individuals health care needs. <u>Medical</u> See section L and N regarding the identification of medical risk factors. <u>Psychology</u> Based on a review of 10 functional assessments, 100% were judged to adequately address individual's behavioral risk. <u>OT/PT</u> Based on a review of individual records for whom assessments had been completed to address the individuals at risk conditions, 100% included an adequate PNMT and/or OT/PT assessment to assist the team in developing an appropriate plan. Although assessments were found to be adequate for identifying risks, it was not evident that assessments were completed prior to the development of IHCPs to address risks or that IDTs met following assessments to incorporate recommendations into the ISP/IHCP.	
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,	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 risks for all individuals designated as high or medium risk in specific areas. All ISPs in the sample included general strategies to address identified risks, but again, not all assessments were submitted prior to the determination of risk ratings, thus, it was	Noncompliance

#	Provision	Assessment of Status	Compliance
	including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	unlikely that risk ratings were based on current data. 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 always possible to determine if IDTs implemented all recommendations from assessments within 14 days. QIDP monthly reviews listed health care plans in place to address risks, however, the QIDPs were not documenting implementation of action steps or reviewing status of outcomes. For example, • Individual #300's IHCP dated 9/26/13 included action steps to address his risk for cardiac disease. The IDT had rated his risk as low even though he was diagnosed with hypertension and hyperlipidemia. He was also a smoker, which increased his risk. The action plan to address his risk included encouraging him to stop smoking, obtain lab work and EKG as ordered, and monitor his weight. DSPs were assigned responsibility for encouraging him to stop smoking, though strategies were not included in the plan. Documentation was not found of implementation. The IHCP did not include what lab work was needed or how often it should be done. The QIDP monthly review did not indicate that if completed, results were reviewed by the IDT to determine effectiveness of supports. Additionally, he had a goal to lose one to three pound every one to three months until within his EDWR. His IRRF indicated that he was within one pound of his EDWR. An acceptable weight range to determine effectiveness of his diet was not included in the action step to monitor his weight. • On 6/12/13, Individual #595's IDT met to discuss concerns regarding his safety. The IDT recommended referring him to a psychiatric hospital due to his psychiatric instability. There was no documentation that the referral was ever made or that any further assessment was completed. His IRRF and IHCP were not reviewed or updated to reflect his change of status. 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. 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., monitor weights weekly, 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.	

#	Provision	Assessment of Status	Compliance
		A review was completed of individual notebooks in the homes and day sites to determine if staff had information needed to provide consistent supports to address risks. IHCP were not found in seven of 12 (58%) of the records reviewed. This concern was identified at the last review, as well. IHCPs should be considered an integral part of the ISP. Direct support staff will need to have access to current plans to ensure consistent implementation of the plan. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following: 1. Develop action plans with measurable criteria for assessing outcomes. 2. Ensure staff have access to the IHCP. 3. Document the implementation of action plans. 4. Document that clinical data is gathered and reviewed at least monthly. 5. Document action taken to revise supports when data indicates that current supports are not effective.	

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 has been designated as the facility's lead psychiatrist o CVs of all psychiatrists who work in psychiatry, including any special training such as forensics, disabilities, etc. o Overview of psychiatrist's weekly schedule o Description of administrative support offered to the psychiatrists o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility o A list of continuing medical education activities attended by medical and psychiatry staff o A list of educational lectures and inservice training provided by psychiatrists and medical doctors to facility staff o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who have a diagnosis of seizure disorder o For the past six months, minutes from the committee that addresses polypharmacy o Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy, including medications in process of active tapering; and justification for polypharmacy o Facility-wide data regarding polypharmacy, including intra-class polypharmacy o For the last 10 newly prescribed psychotropic medications, psychiatric treatment review/progress notes documenting the rationale for choosing that medication; signed consent form; PBSP; HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses have been

	revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) o List of all individuals age 18 or younger receiving psychotropic medication o Name of every individual assigned to psychiatry clinic who 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 o Section J presentation book <u>Documents Requested Onsite:</u> o For the last six months, data regarding refusals including trending data if available. o Copy of the section J presentation book o Copy of the slide presentation from Pharmacy and Therapeutics meeting 12/10/13 o For the last six months, minutes from the psychiatry/psychology meeting o List of all individual's on campus who are edentulous o For the last six months, data regarding psychiatric participation in ISP/ISPA/BSP meetings o For the last six months, data regarding timely psychiatric submission of IIRF information o All data presented, doctor's orders, and Dr. Kendrick's documentation for psychiatry clinic 12/9/13 regarding Individual #888, Individual #604, and Individual #628 o All data presented, doctor's orders, and Dr. Baratang's documentation for psychiatry clinic 12/12/13 regarding Individual #856 o All data presented, doctor's orders, and Dr. Rao's documentation for psychiatry clinic 12/11/13 regarding Individual #195, Individual #393, Individual #198 and Individual #580 o These following documents for the individuals listed: Individual #405, Individual #560, Individual #835, Individual #233, Individual #76, Individual #521, Individual #589, Individual #98, Individual #466, Individual #263 • 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) • QIDP 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 <u>Interviews and Meetings Held</u>: o Christopher Ellis, M.D., Medical Director o Kendall P. Brown, M.D., (Lead Psychiatrist) and Angela Johnson, R.N. o Angela Johnson, R.N., nurse compliance monitor, Section J and Psychiatry assistants: Ms. Virginia Jackson and Ms. Bobbie Hall o Psychiatry staff meeting including Angela Johnson, R.N., Ms. Virginia Jackson, Ms. Bobbie Hall, and Drs. Martinez, Kirby, Kendrick, Rao, and Baratang o Jimmy Tompkins, D.D.S., Dental Director, Sandy German, dental compliance monitor, and Angela Johnson, R.N. o Charlotte M. Kimmel, Ph.D., Director of Psychology o Norris Buchmeyer, R.N., Chief Nursing Executive o Anyssa Garza, Ph.D., Pharmacy Director <u>Observations Conducted</u>: o Psychiatry clinic conducted by Ernest Kendrick, M.D. o Psychiatry clinic conducted by Madhu Rao, M.D. o Psychiatry clinic conducted by Ramil Baratang, M.D. o Clinical Services meeting o Pharmacy and Therapeutics (P&T) Committee meeting o Desensitization Committee meeting o Polypharmacy Meeting

	o Psychology/Psychiatry Meeting o Medical Review Committee
	Facility Self-Assessment: MSSLC continued to use the self-assessment format it developed for the last review. The facility rated itself as being in substantial compliance with five provision items: J1, J2, J5, J6, and J7. The monitoring team agreed with all of these ratings. 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 item listed 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 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. In many instances, although based on additional document review the monitoring team agreed with the facility self-assessment, it was difficult to determine the facility rationale for the assignment of a noncompliance rating. For future self-assessments, it would be helpful if the self-assessment included a rationale for the designation of a particular rating, especially in light of positive data indicating otherwise. 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.
	Summary of Monitor's Assessment: MSSLC met substantial compliance for five sections of provision J (J1, J2, J5, J6, J7) of the Settlement Agreement. The department had a full time lead psychiatrist and four other full time equivalent board eligible/board certified psychiatrists, one of whom had fellowship training in child and adolescent psychiatry. For 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 were areas where integration remained good (e.g., psychiatry and medical, psychiatry

	and nursing). There were areas where improvements in integration were necessary (e.g., psychiatry and psychology). 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. In order to address this collaboration, the facility will need to empower the lead psychiatrist to develop relationships and liaison with other departments. Issues remained with regard to psychiatric participation in the development of the PBSP, psychiatric participation in the ISP meetings, collaborative efforts between psychiatry and psychology with regard to the collaborative case formulation, diagnostic concordance between disciplines, and the identification of target data points for monitoring. As outlined above, 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. In regards to pretreatment sedation, there was minimal pretreatment medication 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 had 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 no evidence, however, that the Reiss screen was being utilized for change of status. This must be addressed in order to maintain substantial compliance in the next monitoring period. 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. In addition, with the implementation of

	AVATAR, the electronic format of the MOSES/DISCUS screens did not allow for clinical correlation and the physician's signature on the electronic document. As such, the forms reviewed during this monitoring visit were incomplete. Pending the resolution of these AVATAR limitations, the facility will need to maintain the paper documents in order to document the clinical correlation portion of the screens appropriately. 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.

#	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 either board certified or board eligible 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. Ramil T. Baratang, M.D., was board eligible in general psychiatry and had completed a clinical fellowship in child and adolescent psychiatry. Maria Martinez, M.D., was board eligible in general psychiatry. Juanita F. Kirby, M.D., was board certified in general psychiatry. Madhu Rao, M.D., was board certified in general psychiatry. In addition, Ernest Kendrick, M.D., had begun providing services at the facility during this monitoring visit in preparation for Dr. Martinez's planned departure from the facility. Given the preparation of the document request prior to his start date at the facility, data regarding his board certification status was not available. Dr. Kendrick did have significant experience in the treatment of individuals with developmental disabilities, having been a provider at MSSLC previously. During the previous monitoring period, 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 were qualified professionals, so the availability of a child psychiatrist must be cited in the self-assessment. In the intervening period since the previous monitoring report, a psychiatrist with specialty training in child and adolescent psychiatry had been retained and was providing services at the facility. It is 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.	Substantial Compliance

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		Experience 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. Maria Martinez, M.D., was contracted to provide services at the facility for a period of approximately six weeks. She had numerous years of experience in the field of psychiatry. She was previously in charge of post graduate training in child psychiatry. Ramil Baratang, M.D., began providing services at the facility in November 2013. He had a history of providing clinical services to individuals with developmental disabilities. Monitoring Team's Compliance Rating 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, and had retained the services of a psychiatrist with specialized training in child and adolescent psychiatry. 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.	
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-	Number of Individuals Evaluated At MSSLC, 257 of the 322 individuals received psychopharmacologic intervention at the time of the onsite review. The percentage of individuals receiving psychotropic medication was consistent with the previous review. Evaluation and Diagnosis Procedures The monitoring team observed three 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	Substantial Compliance

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	certified or board-eligible psychiatrist.	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 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 96% of the QPMRs were done within 90 days since the last visit and that 98% 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 assigned DSM diagnosis. <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 15 records, it was evident that the psychiatric physicians were making effort to provide clinically justifiable evaluations.	

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		Monitoring Team's Compliance Rating The facility had sustained progress with this provision item. The monitoring team agreed with the facility and assigned a substantial compliance rating for this provision item in agreement with the facility self-assessment. 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.	Treatment Program/Psychiatric Diagnosis 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 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.). In the sample of 15 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 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. Emergency use of psychotropic medications: The monitoring team was provided information during the onsite visit that there were 14 chemical restraints from May 2013-October 2013. Conversely, the self-assessment summarized that the facility reviewed "11 of 11 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. Review of the documentation regarding 10 instances of chemical restraint revealed that behavioral interventions were	Noncompliance

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		attempted prior to the implementation of chemical restraints. Data included in the facility self-assessment indicated that in 100% of cases, the individual was seen in an emergency psychiatry clinic within 24 hours of receiving a chemical restraint. Monitoring Team's Compliance Rating 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.	
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 was one administration of pretreatment sedation at MSSLC for the past six months. It was documented that Individual #120 received pretreatment sedation in order to receive an EKG. The IDT determined a desensitization program should be developed for this individual. Note, however, that data 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. Per the facility generated QA/QI data, "tracking of pretreatment sedation now includes both those on and off campus." It was noted that for the months of September, October, and November 2013, there were a total of 23 pretreatment sedations with only one of these occurring on campus. The document further noted that "all pretreatment sedations are discussed during MRC, and a process has been put in place to ensure that the IDT discussion occurs and is documented." Documentation regarding this process was not provided for review. 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. A document entitled "Persons discussed during MRC for Pretreatment Sedation" was provided. Per this document, individuals requiring pretreatment sedation were reviewed at MRC, however, details of this discussion inclusive of recommendations were not provided for review. 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	Noncompliance

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		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 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 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 was only one case example provided for this section and this individual 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	

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		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 to the individual's medical status for each of the medications administered). <u>Desensitization Protocols and Other Strategies</u> A list of all individuals with medical/dental desensitization plans and date of implementation were requested. There was a total of four individuals documented as having dental desensitization plans (Individual #484, Individual #500, Individual #492, and Individual #1). 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. <u>Monitoring Team's Compliance Rating</u> Calculation of pretreatment sedation that was given for dental or medical purposes at any offsite facilities was incorporated into the MSSLC data set, however, corroborating documentation was not provided for review. The facility must also document the clinical consultation regarding the choice of pretreatment sedation agents and any alterations that must be made to the individual's medication regimen in order to allow for the additional medication. 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 for this provision, and the monitoring agreed.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	<u>Psychiatry Staffing</u> Approximately 80% of the census received psychopharmacological intervention requiring psychiatric services at MSSLC as of 12/9/13 (a total of 257 individuals). Of these, 54 individuals were age 18 or younger. There were a total of six FTE psychiatrists at MSSLC. The lead psychiatrist, appointed 2/3/12, was an employee of the facility previously had the responsibility of managing 38% of the clinical caseload in addition to addressing the provision items in provision J. With the addition of an additional FTE, his caseload had reduced to 18% in the month of November 2013. The full-time equivalent psychiatrists had less individuals assigned to them (e.g., 31%, 18%, 14% and 19% of individuals who required psychiatric services). The psychiatric clinic schedule listed each psychiatrist as working 40 hours each week. The psychiatric staff rotated on call a week at a time. The facility reported that each psychiatrist	Substantial Compliance

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		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. Administrative Support 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 also a nurse compliance monitor for section J, Ms. Angela Johnson, R.N. She tracked and trended psychiatric assessments for timeliness and quality, collected and organized data, and assisted in document preparation (i.e., self-assessment, action plans, etc.). Determination of Required FTEs 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). Monitoring Team's Compliance Rating 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 five 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.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	Appendix B Evaluations Completed MSSLC provided data that 98% of the individuals receiving psychiatric services had an Appendix B evaluation completed. In addition, for individual's newly admitted to the facility, data indicated that 100% were seen by psychiatry and completed within the appropriate time limits. Appendix B style evaluations were reviewed for the following 10 individuals: Individual #192, Individual #901, Individual #639, Individual #790, Individual #917, Individual #835, Individual #605, Individual #875, Individual #944, and Individual #401. All Appendix B evaluations included case conceptualizations and history that reviewed information regarding the individual's diagnosis, including the specific symptom clusters	Substantial Compliance

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		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. It is necessary that the case conceptualizations are made via the IDT for improvements in consistency of diagnosis and treatment across disciplines. Treatment recommendations inclusive of non-pharmacological interventions were included in some of the documentation. The assessments followed the Appendix B outline and reflected adequate documentation. Below are comments from the monitoring team. • Treatment recommendations to include indication of each medication and to review potential drug-drug interactions and risk benefit analysis of each medication. • The psychiatrist must guide the IDT in a detailed fashion about what psychiatric target symptoms to monitor in order to determine medication efficacy. • Non-pharmacological interventions outside of the PBSP must be included in the Appendix B documentation. • The facility psychiatry department should consider the implementation of a peer review process to review both Appendix B documentation and other psychiatric work product in order to ensure quality. <u>Monitoring Team's Compliance Rating</u> The facility self-assessment indicated a rating of substantial compliance for this provision. Given the information outlined above, this provision remained in substantial compliance.	
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	<u>Reiss Screen Upon Admission</u> The Reiss screen, an instrument used to screen each individual for possible psychiatric disorders, was to be administered upon admission, and for those already at MSSLC, only for those who did not have a current psychiatric assessment, and for those individuals who had experienced a change in status (e.g., death of a caregiver, relocation to a new home, physical illness). The facility had 32 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. Data provided corroborated this. 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.	Substantial Compliance

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	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 for Change in Status Staff interviews performed during this monitoring visit revealed that in the intervening period since the last monitoring visit, the Reiss Screen had not been utilized in order to assess individual's following a change in status. Once this process is implemented, in the event of a positive screen, individuals must be referred to psychiatry. 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, all individual's residing on campus who were not participating in psychiatry clinic had received the Reiss Screen. Subsequently, all new facility admissions received the Reiss Screen upon admission. MSSLC provided a spreadsheet of all individuals who had 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. Monitoring Team's Compliance Rating The self-assessment indicated substantial compliance, and substantial compliance was achieved during the previous monitoring period. During this monitoring period, it was reported that the Reiss Screen was not utilized for change of status. In order to maintain substantial compliance in the next monitoring period, data must reflect that the Reiss Screen was being utilized in these situations. For this monitoring period, a substantial compliance rating will remain.	
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 dated 8/30/11 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." Facility specific policy and procedure entitled "Psychiatry Services" implemented 7/1/13 indicated "the state center must develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through disciplinary assessments and combined formulation." The policy did not delineate a process for this requirement.	Noncompliance

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		Interdisciplinary Collaboration Efforts In order to address this provision item, the facility had instituted psychiatry/psychology integration forum. The monitoring team attended the psychiatry/psychology integration meeting on 12/12/13. Although it was reported that this meeting was not held regularly, minutes of these meetings were provided for 6/6/13, 6/14/13, 7/18/13, 8/9/13, 8/10/13, 9/20/13, 9/27/13, 10/18/13, 10/25/13, 11/9/13, and 12/12/13. During the monitoring visit, it was reported that there remained challenges in the relationship between psychology and psychiatry. It was apparent that some of the issues derived from a lack of understanding on the part of both departments with regard to what each could/could not do to support the other. In order to ameliorate these challenges, both departments and their respective staff will need to be part of both the discussions and the solution to the interdepartmental issues. For example, 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 institution of the psychiatry support plan should help with regard to identifying target symptoms for monitoring that are tied to an individual's diagnosis. In order for this to be effective, the first step must be collaborative case formulation and cohesive diagnosis (e.g., the same diagnosis reported by each discipline based on the collaborative case formulation). 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, QIDP, direct care professional, and the individual). Medication decisions made during clinic observations conducted during this onsite review were based on relatively brief (minimum 15 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 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	

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		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. 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. It was reported during the monitoring visit that the facility had not begun the process of collecting or tracking data regarding case formulation. <u>Combined Assessment and Case Formulation</u> The case formulation should consist of the following sequential tasks, undertaken to channel distinct disciplinary assessments into the creation of an integrated treatment plan. These steps should include review and integration of information from the disciplinary assessments, identification of factors (i.e., 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. Inadequacies in this process posed problems when implementing a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. <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 determine medication efficacy	

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		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. During the monitoring visit, it was recommended that whenever possible, individual's have consistency in their psychiatric physician. At the time of this monitoring visit, it was noted that if an individual moved to a different home, they would then have a different psychiatrist. It would be advantageous to both the individual and the IDT for this relationship to remain constant regardless of the individual's location on campus. Given that the psychiatry clinics were located in the medical building and the individual's came to the clinic, this seemed to be a relatively easy process to initiate. <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 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	<u>Psychiatry Participation in PBSP</u> During this and prior reviews, the monitoring team noted that psychiatry did not 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, however per discussions with facility psychiatry staff, this process was not regularly occurring. Per the facility self-assessment, of 20 QPMRs between the dates of 4/1/13 to 9/30/13, only eight (40%) documented discussion of the PBSP during the third QPMR. Additionally, a list of all meetings and rounds attended by the psychiatrist was provided to the monitoring team. BTC was not included in this list. 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	Noncompliance

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	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.	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 psychiatry/psychology meeting. Staff reported that this meeting was not held regularly. There was frustration noted on the part of both psychology and psychiatry with regard to behavior support plans in that the behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports, were not chosen due to the identified psychiatric diagnosis. During this meeting, the implementation of the psychiatry support plan, a "method to measure and report back to the psychiatrists on psychiatric behavioral indicators that are relevant to the psychotropic medication" was discussed. The implementation of this process may assist with communication between the disciplines. <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. In the intervening period since the last monitoring visit, psychiatric participation in the ISP process had not improved. Currently, the psychiatric staff indicated they only attended the ISP if they "were invited." Data revealed that even when psychiatry was "invited," they attended only 75% of the time. For example, there were a total of 183 ISP meetings held between the months of June 2013 and November 2013. The psychiatrist's attendance was requested at eight of the 183 meetings. Psychiatry attended six. In a related issue, psychiatry staff indicated that they did not feel "welcome" at the ISP meetings. This is an issue that must be addressed between leadership of the various disciplines (e.g., psychiatry, QIDP, psychology). It is imperative that psychiatry is an active part of the ISP process and attends the ISP meetings, not only upon invitation, but as a regular part of the IDT. <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 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> reviews (e.g., of the	

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		PBSP) were documented in the record and to provide the names 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.	Policy and Procedure A review of DADS policy and procedure entitled "Psychiatry Services," dated 8/30/11, noted that state centers "must ensure that individuals are evaluated and diagnosed by a psychiatrist prior to administration of psychotropic medications…The psychiatrist, in conjunction with the 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 specific policy entitled "Psychiatry Services" implemented 7/1/13 included verbiage from this provision under the section entitled "Psychotropic Medications." It was also noted that during the QPMR meeting, the "psychiatrist leads the discussion and documents results in the Quarterly Psychiatric Medication Review." The list of information to be documented included "risk/benefits/alternatives." Quality of Risk-Benefit Analysis 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 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. 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 documentation noted in the QPMR was generally scant. For example, Individual #157 was prescribed medications including Tegretol XR, Depakote ER, Lithium, Seroquel XR, and Tenex. The risk/benefit analysis stated, "being given instead of Tegretol, due to abuse of Tegretol, and the likelihood of side effects, and drug to drug interactions." This analysis did not describe the risk/benefit for the prescription of five psychotropic medications. In addition, it was not clear what medication was being prescribed in lieu of Tegretol. Alternatives to treatment in this document stated, "BSP and therapy, alternate mood stabilizers." This provision item required the IDT's integration of care involving least restrictive treatment. Unfortunately, it was apparent (from the record reviews by the monitoring team of 15 individuals who were prescribed various psychotropic medications) that psychiatric	Noncompliance

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		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. 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 (see the example regarding Individual #157 discussed above). In discussions with psychiatry staff, it was noted that currently, there was no facility monitoring with regard to either case formulation (e.g., diagnostics) or the risk benefit analysis for the treatment with psychotropic medications. 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. <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 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 QIDP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this section. Recommendations include accomplishing this goal together	

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		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. Human Rights Committee Activities A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the IDT, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). Monitoring Team's Compliance Rating 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 medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Facility-Level Review System The facility had instituted a polypharmacy review system. There was documentation that the polypharmacy committee met on a monthly basis. 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 polypharmacy meeting was observed during the monitoring visit on 12/9/13. During this meeting, four individual's regimens were reviewed. All facility psychiatrists were in attendance. There were some challenges to the regimens reviewed. It was noted that the facility psychiatrists were conservative with regard to dosing, and rather than increasing doses of medication (specifically atypical antipsychotic medications) in order to address increased symptoms, they considered adding another medication from the same class (e.g., Zyprexa and Risperdal). While treatment with two atypical antipsychotic medications may be necessary in some cases, there must be appropriate justification for this practice. 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	Noncompliance

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		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, and inquiries were posed concerning clarification of diagnostics. <u>Review of Polypharmacy Data</u> The results of the December 2013 data indicated the following: • There were 95 individuals prescribed polypharmacy; • There were 236 individuals prescribed psychoactive medications; • 40.3% polypharmacy cases; • One individual was prescribed <u>seven</u> psychotropic medications; • One individual was prescribed six medications; • 8 individuals received five medications; • 25 individuals received four medications; • 55 individuals received three psychotropic medications; • 26 individuals were classified in the intraclass within polypharmacy category • Five individuals received "Pure Intraclass" of two medications The last review, the results of the April 2013 data, indicated there were 95 individuals prescribed polypharmacy of the 253 receiving a psychotropic regimen. Thus, at that time, there were 37.5% polypharmacy cases at MSSLC. Data revealed rationale for the increase in the percentage of individuals prescribed polypharmacy at the facility. There were three individuals admitted to the facility prescribed polypharmacy. In addition, six individuals had changes to their medication regimens and now met criteria for polypharmacy while four individuals had changes to their regimens and no longer met criteria for polypharmacy. <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 IDTs' efforts towards the topic of justification of the	

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		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. The polypharmacy committee must be aware of all medications prescribed, non-psychotropic and psychotropic, for each individual reviewed in order to determine the next plan of action. Individuals with a psychiatric illness, particularly those also with a neurological condition, such as a seizure disorder, must be analyzed in view of their overall medical condition in regard 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 90% of 30 records had a MOSES and DISCUS completed and reported a noncompliance rating for this section. Data presented at the QA/QI council meeting 12/12/13 revealed that for the month of November 2013, nursing began completing MOSES/DISCUS assessments according to the schedule of the Quarterly Psychiatric Medication Review (QPMR) schedule, allowing physicians to review the documents in a timelier manner. Data reflected that 87% of the MOSES/DISCUS assessments due for November 2013 were completed timely and correctly. The facility provided information regarding scores and dates of completion of evaluations dated May 2013 through October 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	Noncompliance

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		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 7/9/13 Individual #309 had both MOSES and DISCUS assessments, but data presented through the end of October 2013 did not reveal a repeat assessment. Interviews of facility staff revealed that previously, nursing staff were performing assessments out of sync with the QPMR resulting in presentation of out-of-date information during clinic. As noted above, the facility had made adjustments to the schedule for MOSES and DISCUS examinations in an effort to address timeliness. 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. <u>Training</u> The annual training for the MOSES and DISCUS was attended by all nurse case managers. 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>Quality of Completion of Side Effect Rating Scales</u> In regard to the quality of the completion of the assessments for the set of scales reviewed (10 examples of each assessment tool), all were completed via AVATAR and, therefore, did not include the clinical correlation section of the form. The physician signed all MOSES and DISCUS results. A review of the QPMR documentation associated with the completed scales revealed that in all cases the scores were documented in the clinic note. In the absence of the clinical correlation or physician assessment included on the paper form of both the MOSES and DISCUS instruments, it was difficult to discern the physician's conclusion. Nine individuals were noted to have the diagnosis of Tardive Dyskinesia (TD). This was a decrease from 11 individuals identified in the previous monitoring report. Although medications, such as antipsychotics and Reglan (Metoclopramide) may cause abnormal involuntary motor movements, the same medications may also mask the movements (e.g., lowering DISCUS scores). No individuals were prescribed Reglan. Medication reduction or the absence of the antipsychotic or Reglan that occurred during a taper or discontinuation may result in increased involuntary movements, restlessness, and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I	

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		diagnosis, such as bipolar disorder. Therefore, all diagnoses inclusive of TD must be routinely reviewed and documented. 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. There were 26 individual residing at the facility who were edentulous. <u>Implementation of Avatar</u> In the intervening period since the last monitoring report, the facility had implemented the Avatar system. This was an electronic database where information, including MOSES and DISCUS, results can be stored. While this was a good step, there were issues with the Avatar system. Specifically, Avatar only allowed for inclusion of the basic form with ratings for each individual exam. It did not allow for documentation of the clinical review of the examination, nor did it allow for an electronic signature of the reviewer. As such, although the forms are uploaded into Avatar, the facility must continue paper documentation in order to allow for completion of the clinical correlation portion of the assessment. This was discussed with facility staff at the time of the monitoring visit. <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 facility nursing and psychiatry administrative staff must work together in order to ensure that MOSES and DISCUS assessments are performed in a timely manner, such that data are relevant at the time of the QMPR. Most importantly, the facility must ensure that the clinical correlation portion of the MOSES and DISCUS assessments are completed. Because AVATAR did not allow for this process, the facility will need to maintain the paper documents in addition to electronic forms. Given the issues discussed above, 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	<u>Policy and Procedure</u> Per a review of the DADS statewide policy and procedure "Psychiatry Services," effective 8/30/11, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." In section 7.b, the policy reflected the language in this provision item. The facility had implemented a facility specific policy and procedure "Psychiatry Services" dated 7/1/13 reiterated the need for integrated clinical services; however, the document did not delineate a specific procedure by which this would occur.	Noncompliance

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	plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	<u>Treatment Plan for the Psychotropic Medication</u> The self-assessment revealed 100% of the 30 records reviewed in preparing the self-assessment demonstrated the treatment plan components for psychotropic medication relevant to this provision item, however, this item was rated 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. While there was continued improvement in the documentation in the electronic QPMR, there remained issues with regard to data presentation. Data presented in psychiatry clinic were variable with regard to timeliness and quality of graphing. In addition, there were many instances where medication adjustments observed in clinic were done in response to anecdotal information as opposed to data. Psychiatrists expressed concern regarding the reliability of data, and that in most cases, data collected did not reflect target symptoms for medication. This made data-driven medication decision making impossible, and resulted in deficits with regard to monitoring the objective psychiatric symptoms or behavioral to assess the treatment's efficacy. Examples of QPMRs in the electronic format were provided to the monitoring team. There was admittedly varying quality of the documentation noted. One example, regarding Individual #916, included information regarding this individual's most recent behavioral challenges. There was also information included regarding this individual's response to his current psychotropic medication regimen. There was documentation that laboratory examinations, vital signs, and MOSES/DISCUS screens were reviewed. A psychotropic medication treatment plan inclusive of all required elements for each medication was noted in the document. In addition, the document indicated the individual disciplines responsible for monitoring of the treatment plan. Although target symptoms related to the prescribed medications were indicated, what was not clear from this otherwise good example of documentation was the review of data regarding the target symptoms and what data points were necessary or currently being collected. In another example, Individual #628 had documented diagnoses, including Bipolar Disorder with psychotic features and ADHD. This individual was prescribed psychotropic medications, including Risperdal and Methylphenidate. The treatment plan for psychotropic medication was completed and nursing completed the quarterly psychiatric medication review worksheet. When reviewing the quarterly psychiatric medication review worksheet provided by psychology, it was noted that this individual had no diagnosis on Axis I, and the target behavior identified for which data were being collected was "stealing." Review of these data would not assist the psychiatrist in making data driven decisions with regard to medication efficacy.	

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		Psychiatry Participation in ISP Meetings 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. Frequency of Consultation with the Psychiatrist 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 via the QA/QI council that indicated issues with timeliness of QPMR. In September 2013 and October 2013, greater than 90% of the QPMRs were held on time. In the month of November 2013, this dropped to 70%. Per documentation provided, the psychiatry clinic was in the process of developing a new system of scheduling to begin in January 2014 in an attempt to ensure that all QPMRs were held within 90 days of the previous review. Psychiatry Clinic During the monitoring review, three psychiatry clinics were observed. The monitoring team observed a psychiatry clinic conducted by three of the six facility 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 15 minutes) with the individual and discussing the psychotropic treatment plan. During clinic, the psychiatrist made attempts to review behavioral data, this was challenging because, in some instances, data presented were over 30 days old. In addition, in the majority of clinic observations, data points identified for collection had little to no concordance with the individual's diagnosis or psychotropic medication. In observed clinical encounters, the individual's weights and vital signs were discussed. In addition, there was increased attention to the use of orthostatic blood pressures and EKG as monitoring tools. MOSES and DISCUS screenings were reviewed, and laboratory examinations were reviewed. Medication Management and Changes The 90-day reviews of psychotropic medication must include medication treatment plans that outline a justification for a diagnosis, a thoughtful planned approach to	

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		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 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 15 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 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.	

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J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Policy and Procedure 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." In addition, it was reported that DADS developed a statewide policy and procedure entitled "Consent for Psychotropic Medications." Facility policy entitled "Psychiatry Services" implemented 7/1/13 included requirements for obtaining informed consent and included a "Consent Protocol for Psychotropic Medications." It will be necessary for the facility to ensure that facility specific policy and procedure regarding informed consent is consistent with statewide requirements. Current Practices 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. Per the facility self-assessment, 98 informed consent documents for new non-emergency psychotropic medications prescribed between 4/1/13 and 9/30/13 were reviewed. It was noted that "the medication plans had a list of pertinent medication side effects…medication plans had a rationale for the use of the medication…the medication plans had target psychiatric symptoms associated with psychiatric diagnosis…side effects listed on these medication plans matched the corresponding consent forms." Per data provided at the QA/QI council meeting 12/12/13, "a total of 37 consents were due for the month of September 2013, 68% of those were outstanding by the psychiatrist. A process was implemented to start tracking consents. In October 2013, a total of 77 consents were due and only 4% were outstanding. For the month of November 2013 a total of 43 consents were due, 35% were outstanding." Given these data, it was apparent that there were delays in the completion of informed consent procedures. Ten examples of informed consent documentation were reviewed. Per this documentation, there were improvements with regard to the documentation of the diagnosis, target symptoms, medication side effects, expected timeline for the therapeutic effects of the medication to occur, risks associated with receiving the medication, benefits associated with receiving the medication, alternatives to treatment, potential consequences of the lack of treatment, expiration of the consent (one year from the date of the document), and signature lines for the individual, their guardian, the psychiatrist providing the explanation, and the director's signature if needed. One issue noted was the designation regarding "I do give consent" versus "I do not give consent." In 7 of 10 examples, although the documents were signed, this designation was not checked. As such, it was not possible to determine if consent was given or not.	Noncompliance

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		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 was one guardian/LAR 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. The facility must ensure that facility policy and procedure are consistent with statewide policy. The facility must improve with regard to completion and timeliness of documentation.	
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 7/1/13 noted wording of the Settlement Agreement under the heading in treatment management. The policy did not delineate a procedure via which this process would occur. <u>Individuals with Seizure Disorder Enrolled in Psychiatry Clinic</u> The monitoring team received a numbered alphabetized list of 62 individuals participating in psychiatry clinic who had a diagnosis of a seizure disorder. Last visit, there were 81 individuals, a data difference of 19 individuals. The reason for this reduction in identified individuals was not clear, as the total population of individuals participating in psychiatry clinic had increased over the course of the monitoring period by 10 individuals. It was reported that there had been an increase in neurology resources (discussed below) with more consistent clinic inclusive of the neurologist presenting information from neurology clinic to the IDT. This may have resulted in some individuals being removed from the clinic roster, however, this needs to be clarified.	Noncompliance

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		Adequacy of Current Neurology Resources The record request for the schedule of the consulting neurologist noted the neurologist came to MSSLC once a month, generally on a Monday. Clinic dates submitted to the monitoring team began in June 2013, though none were provided for October 2013. Per interviews with facility staff, neurology resources totaled 16 hours per month, and data provided revealed an increase in neurology clinics for the month of November 2013, with a total of four clinics. Scheduling information inclusive of appointment times for specific individuals was not included in the documents received. Review of data regarding the last clinical consultation for individuals requiring neuro-psychiatric consultation revealed that of 62 individuals, 14 had not been seen in clinic in the previous year. Given the recent increase in resources, the facility must ensure that all individuals requiring this consultation are scheduled for clinic in a timely manner. Some of the individuals were evaluated by outside providers for neurological care (e.g., Scott and White physicians). During the previous monitoring period, the monitoring team determined that 33% of those enrolled in psychiatry clinic required an IDT review for consideration of a neuropsychiatric evaluation. It was noted at that time that 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. In the intervening period since the last monitoring report, there had been a reported increase in neurology consultative resources. There had also been alterations in the manner in which on campus neurology consultation was provided. It was reported (and documentation supported) that currently, neuro-psychiatric consultation included the neurologist meeting with the IDT inclusive of the psychiatrist to review the neurology clinical consultation and collaborate with regard to recommendations and future treatment. While this process was apparently occurring, there were no policy or procedure documents describing this practice. 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 should continue in order to reduce redundant activities. The drug regimen and drug interactions require a thorough review, particularly for individuals with	

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		intractable epilepsy, and how these variables affect the mental status presentation. Monitoring Team's Compliance Rating The neurologist and psychiatrist must coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder. The facility had begun the process of neuro-psychiatric consultation in November 2013; however, there were no policy or procedural documents outlining the requirements for this process. These must be developed. Data revealed that 22% of individuals requiring neuro-psychiatric consultation had not been seen in neurology clinic in the previous year. In addition, this practice must continue as routine, with documentation available for review in order to determine clinical quality in order for this provision to reach substantial compliance. Currently, this provision will remain in noncompliance in agreement with the facility's self-assessment.	

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 #259 (8/16/13), Individual #104 (5/22/13), Individual #9 (5/31/13), Individual #880 (5/30/13), Individual #597 (5/21/13), Individual #39 (5/28/13), Individual #76 (5/22/13), Individual #268 (5/6/13), Individual #198 (6/16/13), Individual #31 (10/3/13), Individual #224 (8/5/13), Individual #401 (9/14/13), Individual #225 (7/30/13), Individual #18 (8/12/13), Individual #994 (11/13) o Functional Assessments for: • Individual #483 (10/26/13), Individual #373 (8/16/13), Individual #401 (9/5/13), Individual #752 (9/12/13), Individual #997 (7/17/13), Individual #863 (10/23/13), Individual #595 (7/17/13), Individual #13 (10/9/13), Individual #424 (5/10/13), Individual #224 (8/2/13) o Six months of progress notes for: • Individual #259, Individual #104, Individual #9, Individual #880, Individual #597, Individual #39, Individual #76, Individual #268, Individual #198 o Full Psychological Assessments for: • Individual #873 (7/9/13), Individual #424 (11/8/13), Individual #918 (9/4/13), Individual #917 (10/16/13), Individual #715 (9/28/13), Individual #371 (6/28/13), Individual #628 (8/15/13), Individual #676 (8/15/13), Individual #668 (7/9/13), Individual #233 (7/15/13) o Annual Psychological updates for: • Individual #164 (9/26/13), Individual #476 (11/7/13), Individual #279 (11/4/13), Individual #457 (10/8/13), Individual #228 (9/18/13), Individual #159 (8/21/13), Individual #589 (8/14/13), Individual #847 (8/14/13), Individual #183 (8/1/13), Individual #174 (11/4/13) o STARS-Group Counseling treatment plans and progress notes for: • Individual #92, Individual #880, Individual #90, Individual #550, Individual #10, Individual #484, Individual #106, Individual #802, Individual #604, Individual #592, Individual #17, Individual #424, Individual #875, Individual #798, Individual #619, Individual #235 o STARS-Individual Counseling treatment plans and progress notes for: • Individual #211, Individual #449, Individual #595 o Treatment Integrity, IOA, data collection data sheet, undated o Psychology/Psychiatry meeting agenda, 12/12/13 o List of staff that write PBSPs and status of enrollment in BCBA coursework, undated o STARS Committee meeting agenda, 12/10/13

	o Current Census Counts by Home, 12/9/13 o A list of all individuals who are receiving counseling/psychotherapy, 11/18/13 o Data Project, undated o List of dates of psychological assessments for all individuals, undated o Minutes from psychology department meetings for the past six months o List of all individuals with a PBSP, undated o Positive Behavior Support Plans at MSSLC reading level, undated o Section K presentation book, undated o Section K self-assessment, 11/25/13 o Section K action plan, 11/25/13 o Section K PET progress report, dated 11/13 o A list of training conducted on PBSPs, undated o Mean reading level for PBSPs, April 2013-Sept 2013 <u>Interviews and Meetings Held</u>: o Charlotte Kimmel, Ph.D., Director of Behavioral Health o Lupita Alfaro, Psychology Assistant o Behavioral Health Department o Ora Davis, Behavior Analyst o Charlotte Kimmel, Ph.D., Director of Behavioral Health; Molly Ormsby, Assistant Director of Behavioral Health; Amy Dillree, Consulting Behavior Analyst <u>Observations Conducted</u>: o Anger management group therapy session • Staff facilitators: Stephanie Schmidt, Behavioral Health Specialist; Lisa Jones, Psychology Assistant • Individuals participating: Individual #309, Individual #556, Individual #238, and Individual #610 o PET meeting o Clinical Psychology/Psychiatry Meeting Charlotte Kimmel, Behavioral Health; Andrew Griffin, Behavioral Health; Xiaodong Zhang, Behavioral Health; Lupita Alfaro, Behavioral Health; Kendall Brown, Psychiatry; Madhu Rao, Psychiatry; Juanita Kirby, Psychiatry; Ramil Baratang, Psychiatry; Ernest Kendrick, Psychiatry; Angela Johnson, Nursing; Chris Ellis, Medical o Internal Peer Review Meeting • Staff Present: Michael Miller, Behavioral Health Specialist; Ray Matthieu, Behavior Analyst; Charlotte Kimmel, Director of Behavioral Health; Amy Dillree, Consultant BCBA-D; Lupita Alfaro, Psychology Assistant; Molly Ormsby, Assistant Director of Behavioral Health; Temora Gray, Behavioral Health Specialist • Individual Presented: Individual #562 o STARS Task Force Meeting • Lupita Alfaro, Psychology Assistant; Richard Boyer, Stars Program Director; Charlotte

	Kimmel, Director of Psychology Services; Jessica Patton, Behavioral Health Specialist; Molly Ormsby, Assistant Director of Behavioral Health; Temora Gray, Behavioral Health Specialist; Courtney Coker, Behavioral Health Specialist; Jennifer Sanchez, Pre-Doctoral Intern o Psychiatric Clinic • Psychiatrist: Dr. Kendrick • Individual presented: Individual #318 o Positive Behavior Support Plan Training • PBSP for: Individual #414 • Staff conducting the training: Ora Davis, Behavior Analyst o Psychiatry Clinic • Psychiatrist: Dr. Baratang • Individual presented: Individual #856 o Data Project Presentation • Staff present: Amy Dillree, Consulting BCBA-D; Charlotte Kimmel, Director of Behavioral Health; Lupita Alfaro, Psychology Assistant; Ray Mathieu, Behavior Analyst; Molly Ormsby, Assistant Director of Behavioral Health; Megan Baker, Psychology Assistant o PBSP treatment integrity, IOA, data collection reliability session • Individuals observed: Individual #790, Individual #209 • Observer: Ora Davis, Behavior analyst o Supervising behavior health specialists meeting • Charlotte Kimmel, Director of Behavioral Health; Molly Ormsby, Assistant Director of Behavioral Health; Temora Gray, Behavioral Health Specialist V, Jessica Patton, Behavioral Health specialist V, Elizabeth Kadin, Behavioral Health Specialist V o Observations occurred in various day programs and residences at MSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals.
	Facility Self-Assessment: The self-assessment included relevant activities in the "activities engaged in" sections. 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, 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 allowed the behavioral health 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 behavioral health 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, K8, and K11. The monitoring team's review of this provision was congruent with the facility's self-assessment. 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 suggests 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: MSSLC did not achieve substantial compliance for any additional items since the last review. The facility, however, maintained substantial compliance on the four items (K2, K3, K8, and K11) that were in substantial compliance prior to this review. Some improvements since the last review included: • Increase in the flexibility of the data collection system (K4) • Continued development of behavioral systems to ensure that PBSP data are recorded in a timely fashion, are reliable, and PBSPs are implemented as written (K4, K10) • Increase in the percentage of individuals with monthly progress notes (K4) • Increase in the percentage of individuals with a PBSP that have a functional assessment (K5) • Increase in the percentage of individuals with a current annual psychological assessment (K7) The monitoring team suggests that the MSSLC 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) • Expand the collection of interobserver agreement (IOA), and treatment integrity to all individuals with a PBSP (K4, K10) • Establish minimal frequencies of data collection reliability, IOA, and treatment integrity collection, and demonstrate that those frequencies of data collection are achieved (K4, K10) • Establish specific IOA and treatment integrity goals (i.e., how high does IOA need to be), and demonstrate that those levels of IOA and treatment integrity are achieved (K4, K10) • 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) • Ensure that current data are consistently available and graphed at interdisciplinary meetings to increase the likelihood that data based decisions are made (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 PBSPs are consistently implemented within 14 days of receiving consent (K9)

	• Ensure that PBSPs contain replacement behaviors that are functional, or an explanation why functional replacement behaviors are not possible or impractical (K9) • Ensure that all Positive Behavior Support Plans (PBSPs) are clearly based on the hypothesized function of the target behavior (K9) • Provide 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 (K12)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all of the staff at MSSLC who wrote Positive Behavior Support Plans (PBSPs) were certified as board certified behavior analysts (BCBAs). At the time of the onsite review, two (13%) of the 15 staff that wrote PBSPs were BCBAs. Additionally, the assistant director of behavioral health, and the consulting behavior analyst were BCBAs. This is the same number of BCBAs reported in the last review. Additionally, 11 of 15 staff that wrote PBSPs (73%) were either enrolled, or completed coursework, toward attaining a BCBA. This was a decrease from the last review when 85% of the staff 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 behavioral health 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 behavioral health 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-	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	based system to review the quality of PBSPs.		
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 progress in this area. More work, discussed in detail below, is necessary before this provision item can be judged to be in substantial compliance. Since the last review, the MSSLC increased the flexibility of its data system by adding the capability to collect antecedents and consequences of target behaviors to better understand very low frequency behaviors or new target behaviors in two pilot units. It is recommended that MSSLC continue to expand the flexibility of their data system (e.g., duration measures, longer intervals, etc.) and extend it to all treatment sites on campus. In the current data systems, direct support professionals (DSPs) 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 behavioral health specialists (in the systems with multiple intervals per shift) to review data sheets during the shift, and determine if DSPs 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 interval for target behaviors. The target and replacement behaviors sampled for seven of 11 data sheets reviewed (64%) were completed up to the previous hour. These results were similar to those reported in last two reviews (i.e., 69%, 64%). These percentages are below MSSLC's established minimal acceptable level (80%). The facility reported a recent improvement in the timeless of data recording (i.e., data collection reliability) by DSPs in some units (e.g., Barnett), however staff indicated that the frequency of data collection reliability had been variable across all treatment sites. It is recommended that that MSSLC establish a minimal frequency of data collection reliability across all units, and ensure that the established frequency of measurement and minimal acceptable level 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. Another improvement from the last review was the piloting of the collection of IOA data in two units (i.e., Longhorn and Shamrock). The method used to assess IOA appeared to be reasonable. At this point 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.	Noncompliance

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		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. The routine use of data to make treatment decisions was mixed. In a psychiatric clinic for Individual #318, observed by the monitoring team, the behavioral health specialist presented graphs that were current, clearly indicated when important environmental events occurred, and were simple to understand. The clear and current graphs contributed to a very productive discussion by Individual #318's team, and to data based decisions concerning his future course of treatment. In another psychiatric clinic observed (for Individual #856), however, no target or replacement data were presented. As a result of the absence of relevant data presented by the behavioral health specialist, staff were left to speculate concerning Individual #856's behavior, and subsequently treatment decisions were not data based. 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 graphed in increments that encourage data based treatment decisions. Six months of PBSP progress notes were requested, and all (100%) had monthly progress notes. This represented a dramatic improvement from the last review when only 10% of individuals with PBSPs had monthly progress notes. In reviewing at least six months of PBSP data of severe behavior (e.g., physical aggression, self-injurious behavior) for the nine individuals, three (Individual #259, Individual #880, and Individual #39), or 33%, indicated no obvious improvement in severe behavior. This represented an improvement from the last review when 40% of the individual's reviewed showed no obvious improvement in severe behavior. For one (Individual #880) of those three individuals (33%), the progress notes indicated some action to address the 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 acknowledges the efforts by MSSLC to improve the data system, and ensure that PBSP data are recorded in a timely fashion and are reliable. Over the next six months it is recommended that the facility expand the new data system piloted in Longhorn and Shamrock to all units. Additionally, the facility needs to review the data collection reliability and IOA collection procedures to ensure they are consistent across	

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		the facility, and that goal frequencies and levels are established and achieved. Finally, it is recommended that MSSLC ensure that all treatment decisions are data based.	
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 was an increase in the percentage of individuals with PBSPs with current functional assessments, however, this item was found to be in noncompliance 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 monitoring report. A spreadsheet of individuals with psychological assessments indicated that 195 of the individuals at the facility had a full psychological assessment. Twenty-five of the 322 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 a full psychological assessment. Therefore, the facility had 195 full psychological assessments for the 297 individuals who had been at MSSLC for at least three months (66%). This is consistent with the last review when 65% of the individuals at the facility at least three months had full psychological assessments. 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 68 were completed in the last six months, and 10 of these (15%) were reviewed to assess compliance with this provision item. Nine (Individual #371's full psychological assessment 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 was consistent with the last review when 90% of the full assessments reviewed were complete. <u>Functional Assessments</u> A list of functional assessments indicated that 63 of the 276 individuals with a PBSP (23%) had a current (i.e., reviewed/revised in the last 12 months) functional assessment. This represented an increase from the last review when 14% of individuals with a PBSP	Noncompliance

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		had a current functional assessment. All individuals with a PBSP should have a current functional assessment of the variable or variables affecting their target behaviors. 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 is consistent with the last review when 100% of indirect and 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 two reports when all functional assessments included potential antecedents and consequences. 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. As found in the last report, all 10 of the functional assessments reviewed (100%) were judged to have a clear summary statement. All 10 of the functional assessments reviewed (100%) were evaluated to be comprehensive and clear. This is consistent with the last report when 100% of the functional assessments reviewed were evaluated as acceptable. MSSLC continued to produce high quality 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.	

#	Provision	Assessment of Status	Compliance
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	MSSLC's full psychological assessments were not current, therefore, this provision item was rated as being in noncompliance. Although all of the intellectual assessments that were reviewed were current, a review of a spreadsheet of full psychological assessments indicated that 60 of the 195 (31%) were not conducted in the last five years. This represented a slight improvement from the last report when 35% 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 the percentage of annual updates completed. This item was rated as in noncompliance, however, because not all individuals who 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, 256 of the 322 individuals at MSSLC had been at the facility at least one year and, therefore, should have an annual update. Current annual psychological assessments were completed for 128 of these 256 individuals (50%). This represented an improvement from the last review when 37% of individuals who resided at the facility for at least one year had a current annual psychological assessment. All individuals at MSSLC should have a current annual psychological assessment. Sixty-eight annual assessments were completed since the last review, and 10 (15%) were reviewed to assess their comprehensiveness. As found in the last review, all 10 annual updates reviewed (100%) 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. Finally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility indicated that 29 individuals were admitted to the facility in the last six months and all (100%) had an initial psychological assessment within 30 days of admission.	Noncompliance

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		In order to achieve compliance with this provision item, at least 90% of the individuals at the facility will need to have an annual psychological update, and at least 85% of those assessments will need to be judged as complete (i.e., contain a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status). Additionally, at least 85% of individuals admitted to the facility in the last six months will need to have a psychological assessment completed within 30 days of admission.	
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, 182 individuals were receiving psychological services other than PBSPs. Nineteen treatment plans and progress notes (10%) 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 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

#	Provision	Assessment of Status	Compliance
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and 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.	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 276 individuals at MSSLC had PBSPs. A list of all PBSPs and the date of last revision indicated that 271 of these (98%) were current (i.e., revised in the last 12 months). This is similar to the last review when 99% of the PBSPs were current. As reported in the last review, all PBSPs had the necessary consent and approvals. The facility reported that, in the last six months, 53% of the PBSPs were implemented within 14 days of receiving necessary approvals and consents. This is the same percentage of PBSPs implemented within 14 days of receiving consents reported in the last review. MSSLC should ensure that all PBSPs are implemented within 14 days of receiving necessary approvals and consents. One hundred and fifty-five PBSPs were completed in the last six months and 15 (10%) were reviewed to evaluate compliance with this provision item. As found in the last review, all PBSPs reviewed (100%) included operational definitions of target and replacement behaviors. Twelve of the 15 (80%) PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors that appeared to be consistent with the hypothesized function of the behavior and, therefore, were likely to be useful for weakening undesired behavior. This represented an improvement from the last review when 67% of the PBSPs reviewed were judged to be consistent with the stated function. An example of a consequent intervention potentially incompatible with the hypothesized function was: • Individual #259's PBSP hypothesized that his physical aggression was maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). The interventions in Individual #259's PBSP included removing him from the environment following an episode of physical aggression. If avoiding undesired situations were reinforcing for Individual #259 (as hypothesized in the PBSP), then this intervention would likely increase the likelihood of his disruptive behavior. Encouraging (and allowing) him to indicate that he wanted to leave the area BEFORE he engaged in physical aggression would represent an effective antecedent intervention. After the targeted behavior occurred, however, Individual #259 should not be allowed to escape the undesired activity until he appropriately requests it. If the nature of his undesired behavior is such that it is dangerous to maintain him in the activity or situation, then the PBSP should specify his return to the activity when he is calm, and again encourage him to escape or avoid the demand by using desired forms of communication	Noncompliance

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		(i.e., replacement behavior) before he engages in physical aggression. The PBSP needs to clearly state that removal of the undesired activity should be avoided following the target behaviors, whenever possible and practical, because it encourages future undesired behavior. An example of a PBSP where both antecedent and consequent interventions appeared to be based on the hypothesized function of the targeted behavior and, therefore, were likely to result in the weakening of undesired behavior was: • Individual #225's PBSP hypothesized that the function of his aggressive behavior was to gain others' attention and attain desired items (e.g., cigarettes). Antecedent interventions included providing him with staff attention for the absence of target behaviors, and encouraging/reinforcing him for engaging in his replacement behavior (i.e., asking to talk to staff, asking for desired items and waiting patiently if not immediately available) before he was aggressive. Individual #225's intervention following aggression included ensuring safety, but minimizing attention to Individual #225 by directing him to a quiet area away from whomever he targeted. 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. Replacement behaviors were found to be functional (when possible) for 12 of the 15 PBSPs reviewed (80%). This represented a decrease from the last report, when 100% of all replacement behaviors that could be functional were functional. An example of a replacement behavior that did not appear to be functional was: • Individual #39's PBSP hypothesized that his physical aggression was maintained by escaping undesired activities (negative reinforcement). His replacement behavior was to increase following instructions and his daily schedule. These activities appear to be incompatible with physical aggression and included many staff behaviors that have been demonstrated to increase compliance (e.g., ensure clear expectations, praise compliance, etc.). These staff behaviors do not, however, provide the same reinforcer as physical aggression (i.e., escape or avoidance of undesired activities) and, therefore, do not represent a functional replacement behavior. Examples of a functional replacement behavior could be encouraging, and reinforcing, alternative ways to avoid undesired activities (e.g., requesting a break or extra time). 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	

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		majority of PBSPs reviewed), the replacement behavior does not need to be written in the skill acquisition plan (SAP) format. Overall, 10 (Individual #104, Individual #9, Individual #880, Individual #268, Individual #198, Individual #224, Individual #401, Individual #225, Individual #18, and Individual #994) of the 15 PBSPs reviewed (67%) 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 is similar to the last review when 64% of the PBSPs reviewed were judged to be acceptable. In order to achieve substantial compliance with this provision item, the facility needs to document that PBSPs are consistently implemented within 14 days of receiving consent, and ensure that at least 85% of the PBSPs reviewed have functional replacement behaviors (when practical and possible) and that antecedent and consequent procedures are clearly based on the hypothesized function of the target behaviors.	
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.	There were improvements in this provision item, however, more work (discussed below) is required before it could be rated as in substantial compliance. At the time of the onsite review, MSSLC was the collecting IOA in two units (see K4). It is now recommended that the facility expand the collection of IOA to the entire facility. Additionally, it is recommended that MSSLC establish a minimal acceptable frequency of IOA collection, and establish specific IOA goals (i.e., how high does IOA need to be), and ensure that those frequencies and levels of IOA are attained. All of the DSPs 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. This represented another area where the facility had improved since the last review. MSSLC recently began collecting PBSP treatment integrity data. The monitoring team observed the collection of treatment integrity at MSSLC, and believes it represented an adequate measure of treatment integrity. It included several relevant questions concerning the implementation of PBSPs and a direct observation component where the behavioral health services specialist/assistant observed the DSP implementing the plan. At the time of the onsite review, treatment integrity of PBSPs was collected in two units (i.e., Longhorn and Shamrock). It is now recommended that the facility expand the new treatment integrity procedures across the entire facility. Additionally, it is recommended that MSSLC establish a minimal acceptable frequency of treatment integrity collection, establish specific treatment integrity goals (i.e., how high does IOA need to be), and	Noncompliance

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		ensure that those frequencies and levels of treatment integrity are attained. Target and replacement behaviors were consistently graphed. All of the graphs reviewed contained horizontal and vertical axes and labels, condition change lines/indicators, data points, and a data path.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	All of the PBSPs reviewed appeared simple, clear, and allowed for staff understanding. Additionally, all DSPs interviewed, indicated that they understood the PBSPs. Therefore, this provision item continued to be rated as being in substantial compliance. MSSLC utilized an abbreviated behavior support plan that was located in the individual notebooks, and was written so that DSPs could understand them. The monitoring team reviewed 15 PBSPs written in the last six months and concluded that they were written in a manner that DSPs were likely to understand. The PBSPs reviewed were consistently brief and concise, contained a minimal number of target behaviors (the monitoring team's sample averaged 3.2 target behaviors per PBSP reviewed), and technical language appeared to be kept at a minimal. As an objective measure of the readability of PBSPs, MSSLC monitored the reading level (using the Flesch-Kincaid Readability score) all PBSPs written in the last six months and determined that they averaged a 7.4 reading level. Finally, the monitoring team also asked several DSPs across all treatment sites if they could understand the PBSPs, and all DSPs 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 assigned to an individual was trained on his or her PBSP. As reported in the previous review, the psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. Staff trainings were scheduled twice a week, resulting in many DSPs trained each month. Behavioral health specialists and behavior analysts conducted the trainings prior to PBSP implementation and whenever plans changed. All DSPs asked about training during the monitoring team's review indicated that they had been trained. Additionally, the monitoring team observed the training of DSPs on Individual #414's PBSP. The training included a review of the PBSP by the behavior specialist, an opportunity for DSPs to ask questions, and written questions pertinent to Individual #414's PBSP. The monitoring team found the training to be thorough.	Noncompliance

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		Although the facility maintained inservice logs on all staff training conducted by the behavioral health staff, they reported that float staff were inserviced by the residential staff and they did not know the method used to train these staff. 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 a manner similar to that conducted by the behavioral health department) in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter.	
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 322 individuals and employed 15 behavior specialists responsible for writing PBSPs. Additionally, the facility employed nine psychology assistants and six psychology technicians. Two of the facility's behavioral health specialists that wrote PBSPs (another BCBA was the assistant director of the department and did not write PBSPs) had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have at least 11 behavioral health specialists with BCBAs.	Noncompliance

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 #Guideline's for Seizure Management, 7/19/12 o MSSLC Lab Matrix o Clinical Daily Provider Meeting Minutes, May – October 2013 o Medical Review Committee Meeting Minutes, May – October 2013 o Infection Control Minutes, 6/3/13, 10/21/13 o Listing of Medical Staff o Medical Caseload Data o Medical Staff Curriculum Vitae o Primary Provider CME Data 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 #160, Individual #595Individual #268, Individual #43, Individual #456 Individual #470 Individual #917 Individual #867 Individual #285, Individual #892 o Annual Medical Assessments the following individuals: • Individual #752, Individual #330, Individual #500, Individual #228, Individual #238, Individual #365, Individual #504, Individual #347 Individual #117, Individual #479, Individual #497, Individual #441Individual #175 Individual #57, Individual #342 o Neurology Notes for the following individuals: • Individual #500 Individual #455, Individual #488, Individual #40 Individual #381, Individual #31 <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 Kendall Brown MD, Staff Psychiatrist o Madhu Rao MD, Staff Psychiatrist o Juanita Kirby, MD, Staff Psychiatrist o Sheryl Davis, 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 continued to be very brief. For each of the four provision items, it listed one to three activities engaged in to conduct the self-assessment. Realistically, this self-assessment would not be helpful in determining a self-rating because it simply did not reflect the types of activities engaged in by the monitoring team. For example, for provision L1 the self-assessment reviewed only three items: (1) the AMAs, (2) the format of IPN documentation, and (3) preventive screenings. Clearly, such a limited self-assessment could not serve as a valid and reliable tool for determining a self-rating for the provision that addresses the fundamental delivery of health care services. In moving forward, the medical director should review this report, noting the comments and the

	recommendations. As noted in all previous reports, a more pragmatic approach to future self-assessments might be to include more of the metrics used by the monitoring team. The facility rated itself in noncompliance with all four provisions items. The monitoring team concurred with the facility's self-rating.
	Summary of Monitor's Assessment: Progress was noted in some aspects of the delivery of health care services. There was improvement in staffing with the hiring of more full time physician employees. The overall caseloads of the primary care physicians decreased. However, a reduction in caseloads did not result in an improvement in participation in annual ISP attendance. This remained, overall, very low facility wide. Individuals received the basic health care services. The routine screenings, preventive services, and core immunizations were generally provided. The compliance with most cancer screenings was very good and, overall, was increasing. Annual medical assessments were completed in a timely manner and the quality was generally improving. There was significant improvement in the completion of the quarterly assessments. Notwithstanding these improvements, there were continued concerns related to the follow-up of abnormal studies, monitoring individuals who received psychotropics and AEDs, and individuals with recurrent pneumonia. In many instances, monitoring was not completed as required. The fact that adverse reactions and drug toxicity were not infrequent findings pointed to the need to ensure that monitoring occurred as required at MSSLC. The external and internal medical reviews were completed on time and corrective actions were completed. However, there were conflicting reports related to the status of corrective action plans. There was no progress made in the development of a medical quality program and there did not appear to be any sense of urgency to do so. Many of the shortcomings of the medical services were unrecognized because there were no valid and reliable tools to measure the quality of care provided. There was progress made in the implementation of the clinical guidelines issued by state office, but not all guidelines were implemented. MSSLC did not develop local policies based on state issued policies and guidelines. There appeared to be an overwhelming need to develop a set of comprehensive policies and procedures for the delivery of health care services at the facility. Finally, the monitoring team expected to see more progress in several areas in this provision. Staffing had improved and the facility had a core of capable primary care trained medical staff. One problem had been the instability in the medical compliance nurse position, which appeared to have negatively impacted progress in the department. There was a great deal of disorganization associated with this review, data collection, and document organization. The ability to accurately collect and track data <u>does</u> influence the provision of services and will be important as a quality program is developed. It will be important for MSSLC to evaluate the overall management and organization of the department as it relates to the delivery of health care services.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the 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 primary care medical staff was comprised of a full time medical director, two locum tenens physicians, and three full time physician employees. The average caseload was 65 with the largest being 87. Documentation submitted indicated that the medical director did not have the responsibility of a caseload. However, during discussions, he reported that he was very involved in clinical care and continued to provide direct care for many individuals. As has been noted in previous reviews, the medical staffing for the facility was very dependent on the use of locum tenens physicians. Therefore, several changes were once again noted. The exception for this review was that three of the five full time providers were now employees who were very familiar with the facility. Another full time provider had been working at the facility for 10 months. The medical compliance nurse position was filled two months prior to the review. Support for that position continued to be provided by the previous compliance nurse who maintained a full-time position in the psychiatry clinic at the time of the review. **Physician Participation In Team Process** The facility continued the daily 8:30 am clinical services meetings. The medical director facilitated these meetings, which were attended by the medical staff, multiple department heads, and other key staff. The 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. Minutes were 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. This observation was commented upon in the last compliance report. It appeared that such comments were more fitting for an agenda rather than minutes. The department	Noncompliance

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		should have an actual record of the content of the discussion of the meetings in addition to what is intended to be discussed. Again, the topics listed each week were the issues that presented challenges for the medical staff, so it was not clear if the discussions actually occurred on a weekly basis. If the discussions occurred, the outcomes of the discussions were not documented. The medical department maintained data on physician attendance at ISP meetings. Those data are summarized in the table below. Primary Care Provider ISP Attendance 2013 Number of ISPs / Meetings Attended (%) Jun: 34 / 4 (11.7%) Jul: 24 / 6 (22%) Aug: 36 / 6 (16.6%) Sep: 29 / 1 (3%) Oct: 25 / 0 (0%) Nov: 32 / 0 (0%) Total: 180 / 17 (9.4%) The data essentially showed that for the months of June 2013 - November 2013, on average, the medical providers attended 9.4% of the annual ISPs. This was less than the 17% reported during the last compliance review. Much of this appeared to be attributed to the acceptance of the PCP as a non-core member of the IDT. The medical director reported that the PCPs attended when requested to do so. The monitoring team is aware that primary providers are not core members of the IDT, however, a lack of attendance by primary medical providers at annual planning meetings affects the integration of clinical 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 caseloads, however, a reduction of caseloads at MSSLC did not translate into improved attendance in ISP meetings (based on the evidence reviewed). In fact, during a meeting with the medical director, the monitoring team was provided documents to demonstrate evidence of integration of clinical services. The documents showed that one PCP wrote an order for the IDT to meet to discuss supports related to the recommendations of an external consultant. It was clear that the PCP believed the medical issue and recommendation warranted discussion by the IDT. The meeting was conducted as requested, but there was no documentation that the PCP attended. The monitoring team sees this as a good example of the incorrect interpretation of the PCP's involvement in the IDT process. This was discussed with the medical director during the review.	

#	Provision	Assessment of Status	Compliance
		Overview of the Provision of Medical Services Medical care was provided in a clinic format. Each unit had a clinic where individuals were taken to see their physician. A calendar was maintained in each home to record those needed to be seen. The individuals received a variety of medical services. They were provided with preventive, routine, specialty, and acute care services. The facility continued to conduct onsite dental and podiatry clinics. Dental clinic was conducted daily. Podiatry clinic occurred twice a month for half a day. Neurology clinic was conducted onsite each month for the entire day. Other specialty services were usually provided at Scott and White Medical Center. Individuals who required acute care were transferred to local hospitals. When admission was necessary, the individuals were admitted via the on-call MD. The facility maintained a hospital liaison program through nursing services. There were no changes in the provision of laboratory and x-ray services. Labs were drawn and processed at the facility and sent to Austin State Hospital. Stat labs were done at a local hospital and results were available in two to four hours. Radiographs were done onsite and digital images were available immediately. The digital images were read within 24 hours and reports could be available in 30 minutes for stat x-rays. EKGs were transmitted to Scott and White. If abnormalities were found, the cardiologist provided a written report. **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 10 (90%) AMAs were completed in a timely manner • 4 of 10 (40%) AMAs included comments on family history • 7 of 10 (70%) AMAs included information about smoking and/or substance abuse history • 0 of 10 (0%) AMAs included information regarding the potential to transition	

#	Provision	Assessment of Status	Compliance
		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. • 12 of 15 (80%) AMAs included comments on family history • 14 of 15 (93%) AMAs included information about smoking and/or substance abuse history • 7 of 15 (47%) AMAs included information regarding the potential to transition The medical staff was in the process of transitioning to a new format for the annual medical assessment. This format was based on a template issued by state office. Therefore, the records and sample submitted included assessment done in a variety of old formats as well as a few done in the new format. Even the assessments completed in the new format varied widely by provider with some providers placing emphasis on summaries and plans of care for the active medical problems. The assessment of Individual #497 included a particularly good example of a summary that included a list of active medical problems along with the status and plan of care for each problem. Many assessments continued to list summaries, such as "constipation - stable, continue treatment." In some cases, there was no plan of care. The new format was a lengthy one and some sections were repetitive. The risk discussion was a single statement at the end of the assessment. The benefit of the statement was not clear. Most of the statements indicated that that the individuals were at "risk from a medical standpoint." The intent of the medical provider discussing risk is to identify the issues that place the individual at risk, determine if mitigation of risk can occur and when it cannot occur, to ensure that the appropriate supports are in place. Thus, an individual might be at risk for osteoporosis due to AED use and sedentary lifestyle. The AEDs are necessary and will continue. The plan of care to address this would be outlined and might include diagnostics, such as BMD, checking labs, assessment by PT for an activity program, and discussion with the IDT to encourage this. This should occur for each identified risk factor. Overall, the content of the AMAs had improved. Other areas that needed improvement were family history, and the plans of care. For every active problem, there should be a well-defined plan of care rather than a statement, such as continue current treatment. <u>Quarterly Medical Summaries</u> The medical department utilized the state issued template for completion of Quarterly Medical Summaries.	

#	Provision	Assessment of Status	Compliance
		For the records contained in the record sample: • 9 of 10 (90%) records included a QMS for the most recent two quarters. Compliance with this requirement was quite good and significantly improved since the last compliance review. <u>Active Problem List</u> For the records contained in the record sample: • 10 of 10 (100%) records included an APL Most of the APLs were being signed/initialed by the primary providers. They were also being updated regularly. <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 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 or twice. The medical staff consistently initialed diagnostics, such as labs and x-rays and consultation recommendations. However, IPN entries were not always found when those studies were abnormal. Therefore, the plan to address abnormal findings was not always evident. <u>Physician Orders</u> 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. <u>Consultation Referrals</u> The facility tracked consultations with a local database. The state database was not utilized. A total of 40 consults completed after June 2013 was reviewed: • 32 of 40 (80%) 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.	

#	Provision	Assessment of Status	Compliance
		A new IPN entry format was implemented in recent months. It required that the provider summarize the recommendations, document acceptance or rejection of the recommendation, and indicate if the recommendation required referral to the IDT. While the providers appeared to document the consults promptly once they were received, there were major delays related to the receipt of the consults. The medical director noted that the requirement was for documentation within five days of receipt. The monitoring team encountered consults that were not received at the facility for more than two to three months after completion of the appointment. Notwithstanding the physicians' prompt review of the consultation, there was an overall failure to ensure that the services were adequately provided. That is, provision of the specialty services requires that the primary provider receive the recommendations of the consultant in a manner in which he/she is able to make a decision regarding implementation. Some providers, including the medical director, preferred to have a copy of the official consultation prior to making the decision. The facility has a responsibility to establish a system that delivers appropriate and timely services. Ultimately, the primary care physician will be responsible for ensuring timely medical care for each individual. 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. Compliance with cancer screenings improved and explanations were provided, for some individuals, when screening was deferred. Preventive care services, such as cancer screenings and osteoporosis, were tracked in databases. Data from the 10 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: • 10 of 10 (100%) records included PCFSs • 3 of 10 (30%) forms were signed, dated, and current The Preventive Care Flow sheets were found in all of the records reviewed. Many records had multiple versions of the PCFS in the records. The majority of the PCFSs needed updating or completion. Dates of immunizations were not provided and some	

#	Provision	Assessment of Status	Compliance
		information that was available was not recorded. As noted in the last compliance review, there was usually no indication who completed the form and most forms continued to have additional information, such as labs and diagnostics, scribbled in the margins. 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 to writing various diagnostic results in the margins. The forms should be signed and dated in the spaces provided when updated. <u>Immunizations</u> • 9 of 10 (90%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations or had documentation of status • 7 of 10 (70%) individuals had documentation of varicella status <u>Screenings</u> • 9 of 10 (90%) individuals received appropriate vision screening • 8 of 10 (80%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> • 2 of 9 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 48 males: • 31 of 48 (65%) males had current PSA results documented • 17 of 48 (35%) males were overdue for PSA testing <u>Breast Cancer Screening</u> • 1 of 1 females met criteria for breast cancer screening • 1 of 1 (100%) female had current breast cancer screenings A list of females age 40 and older was provided. The list included the names of 42 females, the date of the last mammogram, and explanations for any lack of testing: • 31 of 42 (74%) females had current breast cancer screenings • 3 of 42 (7%) females did not have current screenings due to age • 6 of 42 (14%) females did not have current screenings due to refusal or other reasons • 2 of 42 (5%) females had no explanations	

#	Provision	Assessment of Status	Compliance
		Cervical Cancer Screening • 1 of 1 females met criteria for cervical cancer screening • 1 of 1 (100%) females completed cervical cancer screening within three years A list of females age 18 and older was provided. The list included the names of 44 females, the date of the last pap smear, and explanations for lack of testing: • 29 of 44 (66%) females completed cervical cancer screening in 3 years • 11 of 44 (25%) females did not complete due to age >65 • 4 of 44 (9%) females did not complete for other reasons Colorectal Cancer Screening • 3 of 10 individuals met criteria for colorectal cancer screening • 3 of 3 (100%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list contained 82 individuals: • 71 of 82 (86%) individuals had completed colonoscopies • 4 of 82 (5%) individuals had not completed colonoscopies due to refusal • 2 of 82 (2.5%) individuals had not completed colonoscopies due to refusal by GI provider • 5 of 82 (6%) individuals had not completed colonoscopies due to other reasons Additional Discussion The monitoring team recommends that the medical providers thoroughly document the discussion to discontinue or not complete required screenings. This documentation should include a risk/benefit assessment as well as the discussion with the individual/LAR and the IDT. **Disease Management** The facility implemented numerous clinical guidelines based on state issued clinical protocols. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. Data derived from record audits and the facility reports are summarized below. Pneumonia There were 16 incidents of pneumonia between May 2013 and October 2013. Pneumonia data were reported in multiple documents, such as the AVATAR tracking reports and the Medical Review and Pharmacy and Therapeutic Committee minutes. The total number of incidents reported is listed in the table below.	

#	Provision	Assessment of Status	Compliance

Pneumonia 2013								
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
No. of Incidents	3	0	2	4	0	0	4	6

During the June 2013 compliance review, the medical department provided detailed data in the MRC minutes related to the review of pneumonia. That was not seen during this review. In fact, there was very little information documented in the minutes related to the discussion of pneumonia. The Pharmacy and Therapeutics Committee minutes included a chart that listed the individual, the date of diagnosis, type of pneumonia, nutritional route, diet texture, use of PPI, and oral hygiene status. The pneumonia report was presented during the Pharmacy and Therapeutics Committee meeting observed by the monitoring team. This very cursory discussion included individuals who experienced pneumonia in October 2013. However, there was no discussion of Individual #160 who had a history of pneumonia documented in the active record in October 2013.

The monitoring team was also concerned by the lack of documentation of interventions. That is, there were several individuals who had recurrent pneumonia and it could not be determined what, if anything, was being done to mitigate risk and reduce the recurrence of aspiration. One individual with recurrent aspiration continued oral feedings. It was also observed that the various data sources, such as AVATAR reports, and meeting minutes from the Infection Control, Medical Review, and the Pharmacy and Therapeutics Committees presented different data relative to the type of pneumonia that was diagnosed and the date of occurrence. There was no formal pneumonia review process and there was no procedure in place to guide how this was to be done. The monitoring team had previously recommended that a process for pneumonia review be developed to ensure the process was standardized and consistently completed.

It was not clear that the facility's system was capable of reporting the accurate incidence of pneumonia at MSSLC. This area was demonstrating progress during the June 2013 review. Unfortunately, a significant degree of regression was noted in this area.

Case Examples
Individual #160

- There was documentation in the IPN and physician orders that this individual experienced status epilepticus on 12/6/13. However, the monitoring team saw no documentation that the individual was transferred to an acute care facility for this life-threatening event.
- This individual was treated for pneumonia based on a CXR with a new left lower lobe infiltrate on 10/24/13. This was not reported as pneumonia in the P&T listing in December 2013. The physician order also noted valproic acid

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		toxicity. There was no ADR reported. The valproic acid level on 10/23/13 was 148. The individual had multiple elevated levels over a period of weeks. • The last QDRR in the record was dated 7/19/13 and the last AMA was 10/9/12. Individual #867 • This was a 19 year old with a diagnosis of hypertension. There was no documentation of an appropriate evaluation of secondary causes of hypertension in a young adult. Additionally, the individual continued to be treated with methylphenidate, which could have been the etiology of the elevated blood pressures or the reason for the lack of adequate control. Individual #43 • This individual had a ferritin level of 13.5 in November 2013, which was a decrease from 63 in 12/13. The individual had a history of a colonoscopy, but it was documented as incomplete. The IPNs had no explanation for further blood loss or what evaluation was being done. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 92 individuals. The significance of the data was not clear. Other documentation submitted for section L, which pertained to seizure management, reflected the use of all AEDs, which included a total of 230 individuals. Section L AED use pertains to seizure management and not psychotropic use. 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 appointments occurred with several providers, one of whom was an epileptologist. Neurology Appointments 2013 | | On-Campus | Off-Campus | | Apr | -- | -- | | May | 3 | 6 | | Jun | 6 | 19 | | Jul | 4 | 8 | | Aug | 8 | 9 | | Sep | 8 | 9 | | Oct | 4 | 8 | The overall number of appointments appeared adequate. The monitoring team will need to further evaluate this during the next compliance review.	

#	Provision	Assessment of Status	Compliance
		Documentation of seizure management for 10 individuals over the past 12 months was requested. The facility submitted documentation for only eight individuals listed in the above documents reviewed section. Six of the records were reviewed. Data from those records are summarized below: • 2 of 6 (33%) individuals were seen at least twice over the past 12 months • 4 of 6 (67%) individuals had documentation of the seizure description • 6 of 6 (100%) individuals had documentation of current medications for seizures and dosages • 4 of 6 (67%) individuals had documentation of recent blood levels of antiepileptic medications • 3 of 6 (50%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms • 6 of 6 (100%) individuals had documentation of recommendations for medications • 0 of 6 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc. The medical department did not submit sufficient information for the evaluation of neurology services. Forty-nine pages were submitted for eight individuals. One individual had no information related to seizure management. There was only one record from the onsite neurology clinic and it was essentially illegible. The medical director reported that the scan calls that were conducted with the Scott and White epileptologist no longer occurred. **Access To Specialists** The medical director reported that there were significant problems utilizing the state issued consultation database. Therefore, it was not used for consult tracking. There were numerous accounts throughout the week of the review of the substantial delays related to obtaining the reports of external consults. During the MRC meeting, it was announced that this was recently resolved because MSSLC had been granted access to Scott and White's data system and consults could now be directly retrieved. Notwithstanding this recent improvement, MSSLC was not monitoring the length of time that was required to fulfill appointments. The medical director also reported that there was no system in place to ensure that missed, and cancelled, appointments were promptly re-scheduled. The active records included missed appointment forms that were reviewed by the PCPs. The facility needs a process to ensure that consults are prioritized and completed within the appropriate timeframes and that failed appointments are rescheduled when	

#	Provision	Assessment of Status	Compliance
		appropriate. The facility will need to address the requirement to provide access to specialists as part of the provision of healthcare services. Monitoring of clinic appointments must track the timely completion of clinic appointments based on the determined need and prioritization of the appointment. Moreover, the facility must have a procedure in place to ensure that follow-up of failed appointments occurs in a timely manner. **Do Not Resuscitate** For each compliance review, the monitoring team requests information related to individuals with DNR orders. A list of individuals with current DNR orders was requested along with the clinical justification, date of implementation, and renewals of DNRs. Physician orders, IPN entries, and other information were also requested. The facility submitted a list with three names (Individual #432, Individual #120, Individual #185). The clinical justification was listed as "guardian request" and, although each of the DNRs was more than a year old, the renewal date was cited as N/A. The level of DNR was not specified in the information provided. With no other information provided, the monitoring team was unable to assess the impact of the implementation of the DNR order on the care of the individuals and on the decisions made by the IDT with regards to the medical care provided to the individuals. The monitoring team has documented in consecutive reports that the facility had not provided adequate justification for the implementation of the DNRs. Yet, there appeared to have been no effort to address this issue. The facility's management of DNRs did not appear to be consistent with state policy. 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. The monitoring team recommends that this process be reviewed by facility management and state office. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The medical director should ensure that PCPs are actively involved in the IDT. team process, particularly those individuals with complicated medical needs 2. Documentation issues noted should be addressed. 3. The management of pneumonia should be addressed as discussed above. 4. The medical director should review the specific clinical issues noted in this section.	

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<tr><td></td><td></td><td>5. The medical director should address other issues noted within the body of this report.</td><td></td></tr>
<tr><td>L2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.</td><td><u>Medical Reviews - External</u>
An external medical reviewer conducted Round 8 of the medical audits 9/12/13-9/13/13. State guidelines required that a sample of records be examined for compliance with 46 requirements of the Health Care Guidelines related to the active problem lists, annual medical assessments, documentation of allergies, the appropriateness of medical testing, and treatment. In order to obtain an acceptable rating, all essential items were required to be in place, in addition to receiving a score of 80% on nonessential items. The facility submitted data for the external audits. Those data are summarized in the table below:

<table><tr><th colspan="3">Round 8 - General Medical Audits Compliance (%)</th></tr><tr><td></td><td>Essential</td><td>Non-essential</td></tr><tr><td>Round 8</td><td>85</td><td>95</td></tr></table>
The target scores were not reached in several areas including:
Annual Medical Assessments – past medical history, family medical history, and appropriate plans of care were required.
Preventive Care Flow Sheets were required to be signed and updated.
Responses to the significant lab values were required in the IPN.
Documentation of the MMR administration was required.
The prescribers were required to document a rational for not follow the recommendations made by the pharmacist if the provider chose not to abide by the recommendations.
As noted in Section L1, the monitoring team observed similar findings during the conduct of this review.

In addition to the general medical audits, medical management audits were also completed. The results for the Round 8 medical management audits are listed below.

<table><tr><th colspan="4">Round 8 - Medical Management Audits Compliance (%)</th></tr><tr><td></td><td>Constipation</td><td>Seizures</td><td>UTIs</td></tr><tr><td>Sept 2013</td><td>69</td><td>85</td><td>80</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		The most problematic issues identified by the medical management audits included: • The lack of documentation for continued AED use • The need to utilize non-pharmacologic therapies for management of chronic constipation • The absence of appropriate diagnostic workups for individuals with recurrent UTIs Corrective action plans continued to be developed by the QA department. The facility provided the status of the corrective action plans for Round 8 of the general audits.	

	Total Action Plans	Reviewed By QA	Remaining to Review by QA	Completed	Remaining to Complete
Round 8	46	46	0	46	0

For all audits, a total of 96 corrective action plans were required. The QA department submitted data indicating that QA had conducted audits on all records and 100% of action plans were completed. This contraindicated the comments of the medical director and the documentation found in the self-assessment. The self-assessment indicated that action plans had not been developed.

Mortality Management at MSSLC

Two deaths had occurred in 2013. There were no deaths since the last compliance review. The average age of all deaths for 2013 was 59.5 years.

The mortality documents for the one death which was not reviewed at the time of the June 2013 compliance review was submitted. Information for that death is summarized below:

- The age of the individual at the time of death was 62 years
- The cause of death was severe anoxic encephalopathy.
- No autopsy was performed.
- The individual died during hospitalization.

The monitoring team met with the medical director to discuss mortality management at the facility. The medical director indicated that revisions were made to the facility's Ethics Committee Policy as a result of the mortality review process.

The monitoring team encourages the facility staff to continue to enhance the mortality review process by:

- Ensuring adequate information is reviewed (no less than one year of the records, and two, if possible)

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Ensuring that all hospital information is obtained for review
Having external reviews completed by qualified physicians, such as board certified primary care physicians, with experience in treating individuals with developmental disabilities, when possible.

<u>Compliance Rating and Recommendations</u>
The monitoring team agrees with the facility's self-rating of noncompliance.
To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration:

The medical director should ensure that corrective action plans have been implemented.
Address the recommendations listed above related to mortality management.

</td><td></td></tr>
<tr><td>L3</td><td>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.</td><td>
<u>Internal Medical Reviews</u>
The internal medical audits were completed in September 2013. The results are presented in the table below.
<table>
<tr><th colspan="3">Round 8 - General Medical Audits
Compliance (%)</th></tr>
<tr><td></td><td>Essential</td><td>Non-essential</td></tr>
<tr><td>Round 8</td><td>90</td><td>96</td></tr>
</table>
In addition to the general medical audits, medical management audits were also conducted in accordance with state guidelines. The results for the internal audits are summarized in the table below.
<table>
<tr><th colspan="4">Round 8 - Medical Management Audits
Compliance (%)</th></tr>
<tr><td></td><td>Constipation</td><td>Seizures</td><td>UTIs</td></tr>
<tr><td>Sept 2013</td><td>75</td><td>93</td><td>100</td></tr>
</table>
As noted in Section L2, QA developed corrective action plans for the identified deficiencies and reported that all were completed.

<u>Medical Quality Program</u>
As part of the work done for section H, clinical indicators were developed for aspiration, constipation, and osteoporosis. The medical director presented a cumulative score for all clinical indicators indicating compliance for the months of September, October, and November 2013 was .95, .93, and 1.00, respectively. The significance of these data was not clear and no additional work had been done in that area. There had been no further work in the development of a medical quality program.
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. Work should continue in the development of the identification of the areas that will be assessed for quality. 2. The medical director should seek further direction and guidance from the QA director and the state medical services coordinator related to the development of a medical quality program.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The monitoring team requested a copy of the complete medical policy and procedure manual including all facility policies that were related to medical care and all clinical guidelines developed and implemented. The facility submitted the state medical care policy and state issued clinical guidelines related to management of anticoagulation, constipation, aspiration, and diabetes mellitus. The medical director explained that the only policy that was revised was the ethics committee policy. A local general medical services policy was maintained, but no other local policies were developed related to the provision of medical care. Physicians had received training for several clinical guidelines and these efforts continued. Documentation for this training was maintained and submitted to the monitoring team. The monitoring team also observed the pre-training discussion that occurred during the week of the compliance review. However, full implementation of state issued clinical guidelines had not occurred even though the guidelines were issued to the state centers some 18 months earlier. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The medical department needs a comprehensive medical department manual consisting of policies and procedures related to medical care as well as the overall operations of the department and the provision of health care services at the facility. 2. In addition to the guidelines issued by state office, the facility should have additional guidelines for other common medical conditions such as hypertension, hyperlipidemia, and other identified conditions based upon the needs of the facility. 3. Each member of the medical staff should have a medical department policy and	Noncompliance

#	Provision	Assessment of Status	Compliance
		procedure manual that includes all relevant policies and procedures and guidelines. 4. The department needs a process to ensure that all policies and procedures are reviewed on a yearly basis and updated as necessary.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o MSSLC Section M Self-Assessment, updated: 11/25/13 o MSSLC Section M Action Plan, update: 11/25/13 o MSSLC Section Presentation Book o Active Record Order and Guidelines o Map of facility o MSSLC Nursing Services Organizational Chart, including titles and names of staff currently holding management positions o MSSLC Nursing Department last six months the number of budgeted positions, staff, unfilled positions, current FTEs, staffing patterns for resident areas by shift; overtime, contract nursing hours; and staffing maximums and minimums o MSSLC last six months Nursing Weekly Focus Meetings o MSSLC New Employee Orientation agenda o MSSLC QA/QI Council Meeting Quality Assurance Reports o MSSLC Clinical Monitoring Meeting Minutes, 12/9/13 - 12/13/13 o MSSLC Alternative Medical Care Facility Status Report, 12/9/13 and 12/13/13 o MSSLC Continuous alternate of movement tracking record, 12/1/13 – 12/12/13 o MSSLC Nursing Policies & Procedures o SSLC Infection Control Reference Manual for SSLC, dated: 2011 o SSLC Hospitalizations, Transfers and Discharges, 6/11 o SSLC Health Care Guidelines, 5/09 o SSLC Nursing Services Policy #010.2, effective: 6/17/13 o MSSLC Line listing by RN, LVN, Nursing Competency/Skills Testing, 11/13 o MSSLC Nursing Services Comprehensive Review Format, 9/30/13 o MSSLC Nursing Care Plan Audit Tool (new) 11/13 o MSSLC Annual Nursing Comprehensive Review/Physical Assessment Tool/Instructions Audit Tool (new) 11/13 o MSSLC Documentation of Nursing Discharge Summary Review Audit Tool (new) 12/13 o MSSLC Listing AED and Emergency Bag Locations o MSSLC AED and Emergency Equipment Check List: 11/1/13- 12/12/13 o MSSLC last six months Summary and Analysis Review of AED and Emergency Equipment Checklists o MSSLC Listing of CPR/First Aid Certifications o MSSLC Administration of Oxygen, Home Life & Training Manual Nursing Services EP11, 2/15/02 o SSLC Emergency Response Policy #044.1 effective: 9/7/11 o MSSLC last six months, all code blue/emergency drill reports, including recommendations and/or corrective action plan o MSSLC last six months, nursing audits, data analysis, reports, sample size, staff completing the

	audits and plans of correction o MSSLC listing of Mealtime and Snack Integrated Progress Notes (IPNs) and Meal Time Observations conducted Face-to-Face monitoring by RN Case Managers o MSSLC Compliance Monitoring Universal Monitoring Form, revised: 2013 o MSSLC Alphabetical list of individuals with current PSP, annual nursing assessment, and quarterly nursing assessment (due) dates o MSSLC Alphabetic list of individuals with Gastrostomy, Jejunostomy, G/J tube, tracheostomy, colostomy, ileostomy, Foley catheter, and Port-A-Cath by residence o MSSLC Enteral Nutrition Meeting minutes, 10/17/13 o MSSLC Nursing tracking Reasons for Eternal Tube Changes 9/12 – 11/13 o MSSLC list of individuals ever diagnosed with human immunodeficiency virus o MSSLC 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 of unit and date of diagnosis o MSSLC current Immunization Tracking report, 11/13 o MSSLC last six months infection control trending reports o MSSLC Infection Control Committee Meeting and Skin Integrity Meeting Agenda and associated documents, 12/9/13 o MSSLC Guidelines for Acquiring, Administering and Documentation of Individual's Immunizations, 7/23/13 o MSSLC Focus News Publications, 6/13 – 11/13 o MSSLC Hand Hygiene Monitoring Compliance reports, 1/13 – 11/13 o MSSLC last six months, minutes from the following meetings: Infection Control, Skin Integrity, Specialty Nurses Meeting, Nurse Manager Meeting, Weekly Nursing Focus Meeting; Pharmacy and Therapeutics, and Medication Error Committee Meeting o MSSLC last six months Antibiograms o MSSLC Weekly Focus Meeting Summary for Longhorn, 12/11/13 o SSLC Enteral Medication Administration, 5/11 o SSLC Medication Variance Policy #053, effective: 9/23/11 o MSSLC Medication Variance Review Committee (MERC) Agenda for October Data, 12/12/13 o MSSLC last six months, MERC meeting minutes o MSSLC last six months number of medication variances by error type, discipline, home, shift, unit individual, category of severity, and error mode o MSSLC last six months medication administration observations, medication room and, medication administration record audits, analysis reports plans of correction, and blank forms o MSSLC last ten medication variances, and applicable performance counseling o MSSLC list of individuals at risk of aspiration, cardiac, challenging behavior, choking, constipation, dehydration, diabetes, GI concerns, hypothermia, injury, medical concerns, osteoporosis, polypharmacy, respiratory, seizures, skin integrity, urinary tract infections, and weight o MSSLC QA Nurses enteral project reports completed 12/12 – 11/13 o MSSLC last six months minutes Nursing Quality Assurance/QA/QI provision M data

	o MSSLC Clinical Death Summary, and other records/reports used in the completion of the summary o MSSLC Nursing Corrective Actions related to Mortality Reviews o Records of: Individual #17, Individual #331, Individual #273, Individual #43, Individual #31, Individual #567, Individual #160, Individual #407, Individual #779, Individual #468, Individual #934, Individual #875, Individual #406, Individual #698, Individual #305, Individual #236, Individual #335, Individual #253, Individual #236, Individual #305, Individual #698, Individual #420, Individual #197, Individual #261, Individual #589, Individual #38, Individual #398 Individual #148, Individual #188, Individual #479, Individual #159,Individual #287, Individual #65, Individual #916, Individual #456, Individual #216, Individual #261, Individual #105, Individual #285, Individual #185, Individual #657, Individual #790, Individual #115 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Norris Buchmeyer, RN, BSN o Nursing Operations Officer, Katrina Edwin, RN,BSN o Nurse Compliance Monitor, Gabby Brewer, RN o RN Case Manager Supervisor, Mitzi Daniel, RN, BSN o Infection Control Preventionist, Phillip Morton, RN, BSN o Hospital Liaison, Rosemary Roberts, RN o Nurse Educator, Genia Duke, RN o Nurse Managers o Quality Assurance Nurses, Karen Wilson, RN, Dawn Price, RN o Campus RN, Direct Care RNs, LVNs, RN Case Managers, and Direct Support Professionals (DSP's) o At-Risk meeting – 12/12/13 <u>Observations Conducted</u>: o Medication Administration Observation (all units) o Enteral Administration of Medications (various units) o Residential areas at various time of the day o Emergency Equipment (various and mobile units) o Infection Control Committee meeting - 12/9/13 o Skin Integrity Committee meeting - 12/9/13 o Nursing Administration Meeting - 12/10/13 o MSSLC Clinical Services Morning Meeting - 12/10/13, 12/12/13 and 12/13/13 o Longhorn Weekly Nursing Focus meeting, - 12/11/13 o CLDP meeting - 12/11/13 o ISP meeting - 12/12/13 o MERC meeting - 12/12/13
	Facility Self-Assessment: MSSLC submitted its self-assessment, which was updated on 11/25/13. The self-assessment for the facility

	described each provision item, the activities and actions, and the status of the actions. The CNE and nursing leadership are credited with their continued efforts to ensure that their actions and responses for the self-assessment were aligned with the monitoring team's subject matter. Throughout the self-assessment several of the actions steps were noted to be in process for more than 12 months, and it was apparent several were ongoing day-to-day operational practices. For example, staff reporting for duty via a call in system. The CNE should develop ways to measure the action step, thus, the identification of progress toward the action step for those with assigned dates of six months or longer. For example, action step will meet a goal within set time frame toward an overall benchmark The facility conducted its self-monitoring using real-time audits. However, in reviewing the tools (Section M, Nursing Annual Comprehensive Review/Physical Assessment Tool, and Acute Illness and Injury Monitoring Tool), the monitoring team found most audits failed to contain identifying information, as structured by the tool. This was a consistent problem in reviewing the submitted audit tools. The facility rated itself as being in substantial compliance with sections M2, M4, and M6, and in noncompliance with the other three provisions. The monitoring team agreed with the facility's self-ratings except for M2, which the monitoring team found to be in noncompliance.
	Summary of Monitor's Assessment: MSSLC sustained many of the improvements implemented at the time of the last monitoring visit and continued to make further improvements in all of the provisions of section M. During the review, through direct observations and posed questions to the nursing staff, it was consistently apparent that the MSSLC Nursing Department's expectations for providing nursing care (e.g., nursing procedures) were based upon accepted standards of care. Further, the nurses consistently, when queried, stated that the individual's primary care provider, or on call primary care provider, responded promptly to their questions/concerns no matter the time of day or night. Nursing leadership also reported a very positive and collegial relationship with the medical director. During the onsite monitoring review, documents were reviewed and many residential areas were visited. The visits included observations of nursing assessments and nursing procedures. Fifty-two nurses were observed in various settings. Of that the total, 14 were RN Case Managers who were visible, and engaged with the individual during various times of the day and evening on the units; this was much improved since the last visit. In addition, a number of new action steps were implemented toward the development of new systems to improve upon assessments and in the delivery of quality care. The RN Case Manager had put in place systems to ensure the delivery of timely and quality nursing assessments, and developed tools to monitor those systems. The Infection Control Preventionist had made significant progress in the implementation of systems to assure systems were in place to facilitate identification of increases in infections, as well as clusters and outbreaks. The prevention of spread of infections was accomplished by the use of hand hygiene, standard

	precautions, and other barriers. During the record review, it was revealed that there continued to be much work needed toward improvement in risk identification and monitoring, to ensure individuals and staff were knowledgeable of their identified risks, specifically those health conditions that were chronic. There continued to be many positive changes, and there was potential for many more accomplishments over the next six months.

#	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 monitoring team conducted its own independent review of the facility's self-assessment, action plans and information presented in section M. The monitoring team held meetings and interviews with the CNE, Nurse Educator, Compliance Officer, RN Case Manager Supervisor, Infection Control Preventionist, Hospital Liaison Nurse, Campus Nurse, Nurse Managers, direct care nurses, and direct support professionals; reviewed individuals' records, interviewed and observed on the units, and attended at variety of meetings. During the monitoring review, all presentation books and documents submitted by the facility were reviewed, residential areas were visited, daily observations of nursing care were made, 52 nurses were interviewed, and 44 individuals' records were selected for a focused or a comprehensive review. Of the total number, 12 records were selected for a comprehensive review. The monitoring team directly observed 11 of the 12 individuals in their homes, at their work/day settings, and/or during medication administration times. Since the prior review, MSSLC reported a number of actions that were taken to achieve substantial compliance with this provision item. Of the total 28 actions, 25 (89%) were new actions, initiated since the last monitoring visit. Of the 25, 21 (84%) were reported as completed. Of the remaining actions steps, one was dependent upon the facility process for obtaining and approving bids for protective shelter for the Campus RN's emergency vehicles. The remaining six were reported to be in process; and all had been ongoing since November 2012, as a part of the Nursing Department's continuous oversight and monitoring to ensure completion of a minimum set of real time monitoring tools monthly, shoulder to shoulder onsite teaching, addressing illegible and/or inappropriate documentation, and omissions of documenting the time of day physicians were notified. According to the facility's self-assessment, however, "after a comprehensive review of assessments completed M1 remains rated as noncompliant" because "of the inability to maintain consistently high scores that require complete documentation." The monitoring team agreed.	Noncompliance

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		Staffing, Structure, and Supervision Since the prior review, the CNE had completed the analysis of the data submitted by MSSLC nursing staff related to nursing functions/activities in order to evaluate staff assignments, and measure acuity. The CNE established, by unit, a maximum and minimum staffing pattern for LVNs. he establishment staffing standards provides a more equitable nurse to resident ratio related to unit acuity. During the past six months, the facility experienced a total of seven shifts over a period of five days by LVNs that fell below minimum staffing. As the nursing department had established minimum standards, the facility should continuously continue to ensure that there is a process in place to ensure there is sufficient staff to meet the minimum standards, at all times. The CNE reported coverage was addressed through the assignment of direct care RNIIs to assist with nursing assessments and procedures, thereby, ensuring care and services were not interrupted. MSSLC at the time of this review, had 152 nursing positions of which 133 (88%) were filled. The facility continued to have the need to use agency staff to fill their vacancies, due to recruiting issues that fell outside of the facility's capabilities to attract and hire. To the credit of the CNE and nursing leadership, as a part of their recruitment and retention program, they developed measurable performance standards for promoting nurses. The Nursing Department had maintained its nursing leadership positions, which had a positive impact on MSSLC to be able continue to sustain and make improvements in section M. The Nursing Operations Officer (NOO) developed a questionnaire to ensure new hires were assigned, based on skills, knowledge and abilities. In addition, the Nursing Department held both monthly and weekly focus meetings, keeping the nursing staff up-to-date on relevant issues (e.g., observations with certain new pain medications, reinforcement nursing assessments, nursing procedures) and providing positive feedback to nursing staff on areas of accomplishment and needed areas of improvement. The facility also continued its mentoring/preceptor program, which provided nursing supervision and oversight. Availability of Pertinent Medical Records • During the onsite visit, records were accessible, including the individual's All About Me Book (i.e., individual notebook), which contained the instructions for staff. The monitoring team noted one record contained instructions for health care problems that was considered resolved. Although the RN Case Manager reported a previously assigned RN Case Manager had the case, she immediately took action to address the monitoring team's concern. • The facility provided its documentation of review of each individual's immunization status. However, because the data did not contain an analysis, the monitoring team was unable to discern the number/percentage of individuals	

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		who were up to date with their vaccines/immunizations. • The monitoring team completed a comprehensive review for the current month, and last three months of the nursing entries for Individual #17, Individual #331, Individual #273, Individual #43, Individual #31, Individual #567, Individual #160, Individual #407,Individual #779, Individual #468, Individual #934, and Individual #875 and found: o 12 of 12 (100%) were documented in the SOAP format o 9 of 12 (75%) were not written below the last line on the page o 10 of 12 (83%%) entries were legible o 9 of 12 (75%) contained date, military time, and nurse's signature and title o 9 of 12 (75%) documented continuation of the note o 10 of 12 (83%) were found without any documentation errors <u>Hospitalization and Hospital Liaison Activities</u> As recommended by the monitoring team, the facility had obtained access to remotely review "real time" hospital/emergency records electronically, from one of its major medical providers. The Hospital Liaison Nurse and Hospital Liaison Nurse Assistant continued to follow-up on all hospitalizations, attend individuals' post-hospitalizations ISPAs, and attend the Clinical Morning Meetings. In addition to these activities, the Hospital Liaison Nurse instituted and maintained a database containing by date, home, individual's name and case number, receiving ER/hospitalization, reason sent out, treatment received, discharge dates, post hospital issues, and discharge diagnosis; and movement/alternate placement information about the individual. At a glance, this information provided valuable information to the IDT regarding individuals who had frequent hospitalizations and emergency room visits and their movement, such as from home to home, etc. However, there was no additional explanations as to how the information was utilized by the facility, specifically for looking at patterns and trends related to health and movement. The Hospital Liaison Nurse, during an interview with the monitoring team, reported she or the Assistant Hospital Liaison participated in the following activities: • Conducted visits and follow-up visits/contacts to hospitals for all hospitalizations • Obtained, reviewed, and distributed hospital information to teams • Completed and distributed Hospital Liaison Reports, to include documentation in the IPN notes • Entered data into Avatar related to hospitalizations • Attended ISPAs related to post hospital discharge	

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		The Hospital Liaison Nurse conducted monitoring tools for Urgent Care/ER. For the period of 3/13 through 11/13, the overall compliance rate was 93%. The Hospital Liaison was well versed in her role, responsibilities, and reporting duties in order to ensure that individuals had access prior to and after discharge for necessary equipment or services. For example, she attended hospital discharge meeting and any post hospitalization ISPAs, Clinical Morning meetings, etc. The Hospital Liaison reported that when onsite hospital visits are made, she observes the individual and communicates with the DSP staff who are supporting the individual in the hospital (but she does not typically review the DSP observation notes). The rationale provided by the Hospital Liaison Nurse was that the notes were often a duplication of information she had already obtained from the hospital nursing staff. The monitoring team reviewed five of the most recent Hospital Liaison Reports for Individual #43, Individual #407, and Individual #273 and found: • Five of five (100%) hospitalizations had a documented contact by the Hospital Liaison Nurse or designee. Of the five, four (80%) had follow-up by the Hospital Liaison Nurse within 24 hours (although not required by policy). • Five of five (100%) contained follow-up contact Hospital Liaison IPN notes, written in SOAP format. • Five of five (100%) of the Hospital Liaison Reports/IPN notes contained information about the individual's diagnosis, medications, lab work, procedures, and plans for discharge. • Five of five (100%) Hospital Liaison IPN notes documented hospital nurse/physician to facility nurse/physician report, report to RN Case Manager, and evidence of ISPA meeting. For example, the monitoring team reviewed Individual #273, who was hospitalized on 11/12/13 and subsequently transferred from the hospital to a long-term care unit for intravenous antibiotic therapy on 11/15/13. The Hospital Liaison reports evidenced daily follow-up on the individual's medical plan of care during the time the individual was a resident at the long-term care facility. The Hospital Liaison Nurse, in addition to the visits, ensured information from the hospitalizations and/or long-term care facility, were obtained and made available in the individual's record. The Nursing Department had sufficient systems, processes, and procedures in place to ensure Hospital Liaison activities were completed timely and that there were activities to ensure integration of continuity of care for the individual, between the facilities and within the MSSLC teams. MSSLC met the standard for this part of section M1.	

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		Infection Control The Infection Control Preventionist (ICP) continued to implement ongoing monitoring for infections among individuals that live and work at MSSLC and subsequent documentation of infections that occurred. The ICP carried out the daily functions of the Infection Control Program that included: • Monitors healthcare-associated infections • Assesses infection control problems and makes recommendations for corrective action • Consults with physicians and department heads as needed to improve care • Conducts outbreak investigation and initiates control measures • Provides education and training (e.g., contact precautions) • Provides consultation to the facility for environmental and infection control practices (e.g., dietary, housekeeping services) Since the last monitoring the visit, the ICP is credited with conducting a Urinary Tract Infection study, to determine the underlying problems related to urinary tract infections. The study included a "Urinary Tract Infection Interdisciplinary Protocol" as part of their prevention strategies in minimizing the infections, along with nine recommendations. Reportedly, the report was presented to the Infection Control Committee. When the monitoring team reviewed the last six months of minutes and the current 12/9/13 agenda, the subject of the study was included in the 10/21/13 minutes, but there was no indication of IC committee review of the study and approval of the recommendations. The facility also completed Antibiograms, which provide valuable data to the infection control committee regarding antibiotics that were sensitive or resistant to the organism found to cause the infection. Although the facility had not experienced a significant decrease in the number of urinary tract infections, the facility had taken steps in evaluating and making many positive recommendations toward minimizing urinary tract infections. The facility should also consider tracking infections as to whether or not they were hospital-acquired or community- (i.e., facility) acquired. And for urinary tract infections, ensure the data distinguish between those that were device-associated and those that were not (e.g., Foley catheters). The monitoring team will follow-up at the next visit as to what actions have been implemented specific to the recommendations from the study. The monitoring team interviewed the ICP and found the ICP maintains two databases for UTIs, one was for a clinically diagnosed UTI, and one was in accordance with national standards for epidemiological surveillance definitions. The facility's Infection Control Committee should consider utilizing nationally accepted definition standards for reporting	

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		its infections. MSSLC undertook a robust campaign to ensure individuals and staff were educated on standard precautions. The education focused on the preventions in the spread of organisms. For example, the importance of not sharing food, drinks, or cigarettes. In addition, when infections were identified and required "contact isolation," additional training was provided. The monitoring team, during the onsite visit, observed a home where "contact precautions" were in place, and was impressed to find the DSP staff were knowledgeable about the individual's health condition and the rationale for the "contact precautions." In another residential area, the housekeeping attendant was also able to report on the education and training he had received in response to the prevention of organism infections. The facility Infection Control data also revealed a significant decline in the number of cases of cellulitis from the last monitoring visit. From 1/13 through 4/13, there were 28 infections (four months of data). Since the last monitoring report, from 5/13 through 9/13, there were 17 infections (five months of data). The ICP also reported that he, or his designee, conducted "real time" infection control audits and hand hygiene audits. He tracked compliance with Tuberculosis Skin Testing and Flu Vaccinations. The overall results for these audits were as follows: [redacted] Reportedly, the 35% number also included staff who, for certain reasons, declined to accept the vaccine. The ICP should consult with the medical director to discuss how together they might be able to improve upon their existing campaign efforts. The ICP and Infection Control Committee should continue its efforts to reduce all infections.	

Audit	Review Period	Overall Compliance
Hand Hygiene	1/13 through 11/13	99.70%
"Real time" Infection Control	7/13 through 11/13	100%
Infection Control	1/13 through 11/13	90%
[redacted]		
Tuberculosis Skin Testing Policy	100% Compliance of Individuals and Staff 5/13 through 10/13	
Flu –Individuals	94% (11/15/13)	
Flu – MSSLC Staff	35% (11/15/13)	

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		Wound and Skin Integrity The monitoring team attended the Wound and Skin Integrity meeting chaired by the CNE. During the meeting, documents were provided for discussion. The monitoring team had difficulty in reviewing the documentation due to overcrowding of the data in the documents. During the meeting, information was provided that the facility had only one decubiti, which was hospital-acquired. This was a decrease from the last monitoring visit. Information provided in the meeting discussed contributing factors to the hospital acquired decubitus, that is, that it was most likely due to the extended time the individual had to remain in the emergency room waiting to see a physician or for procedures. The stretchers are primarily used to transport, and typically do not have the capacity to support equipment designed for hospital beds, for example air mattresses, used in the prevention of pressure areas. The CNE reported there were ongoing communications between the facility and hospitals to minimize the occurrence of decubiti. However, prolonged lengths of time in emergency rooms were problematic, but these were not under the control of MSSLC. A review, by the monitoring team, of the last six months of the Skin Integrity Committee Meetings revealed that wound and skin issues were tracked by occurrence and by type of wound. The facility reported that "M5 and M6 have the most issues. M5 and M6 have accounted for 72.7% of all care related issues for the Martin unit." The facility focused on ensuring staff were trained on hygiene issues and standard precautions. The data included information in reductions in the number of skin problems occurring on M5 and M6. Even though M5 and M6 continued to account for the highest totals, there was improvement. Emergency Response A review of the state of medical emergency equipment and response at MSSLC revealed that all of the emergency equipment in all areas (inspected by the monitoring team) were operational, and that the emergency checks were performed daily. There was much improvement since the monitoring team's last visit. The nurses in each of the units were observed to be proficient in each of the operational checks (e.g., suction machine, oxygen, AEDs). Since the last visit, and in response to a finding from the monitoring team, the facility now had two accessible vehicles, new organized emergency bags, and back up emergency bags. The NOO is credited in providing the direction and oversight to ensure the Campus Nurses involvement in the structuring of the emergency bags; that is, the Campus Nurses were assigned responding to urgent/emergent calls. The Campus Nurses also sought outside resources to review the most current supplies in the development and organization of the bags. In addition, the monitoring team reviewed Emergency Checklists for 12/1/13 through 12/11/13 and found Shamrock Medical had omissions for emergency checks occurring on	

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		12/6/13 and 12/7/13. There were no explanations or codes for the omissions noted on the checklist. The facility emergency response minutes documented, for the previous six months, an overall compliance check of 97% for emergency checks. The monitoring team reviewed the last six months of the Medical Emergency Response Meeting Minutes and found the following new positive actions to supplementing their existing emergency response systems. These included: • Abdominal thrust training vest (training was implemented in 5/13 for pre-service and annual training) • Portable suction machines • Automatic External Defibrillators location signs for areas with AED's • Labeling of operational and non-operational electrical plugs The minutes began in September 2013 to include a more useful format when representing the number of CPR drills and the percentage of pass/fail. Although the minutes noted the number of failed drills and contributing problems (e.g., nurse did not show, operator failed to call nurse in timely manner), the minutes did not contain any follow-up as to actions taken or outcomes from actions. The monitoring team could not discern, from the data presented in the September/October 2013 minutes, the numbers and percentages of pass/fail for CPR because different sets of numbers were reported. Following the onsite review, the facility reported that CPR drills were reviewed in the daily IMRT meetings and during these meetings corrective actions were determined, and systemic problems were referred back to the emergency review committee. Another notable improvement was that the facility emergency system now had the capability to allow staff with a cell phone (to include personal) to activate the emergency system using a universal number, in addition to their existing MSSLC communication systems. A back up plan was in place to ensure that, in the event of two emergencies occurring at the same time on campus, both 10 pm to 6 am nurses will respond as a back up to the Campus RN. Both the Campus Nurse and the 10 pm to 6 am nurse had the capability of communication through the issue use of mobile radios. <u>Quality Enhancement Efforts</u> The Nursing Department Quality Enhancement Efforts included ascertaining the underlying reason for an individual's hospitalized acquired changes in skin integrity. Reportedly, findings included long waits in emergency room on stretchers that did not accommodate equipment, such as devices that aid in the prevention of pressure areas. The facility continued to follow-up on individual cases with tertiary care facilities in ways to minimize the development of pressure areas. The monitoring team will follow-up at the next visit as to any additional collaborative progress the facility and tertiary care facilities	

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		have engaged in to reduce the number of acquired hospital changes in skin integrity (i.e., decubitus ulcers). The facility continued to audit the record each week and tracked blanks, overages, shortages, physician notifications of shortage, legibility, and other documentation. Findings from these audits were presented in a newly established Enteral Nutrition Meeting. The focus of the meeting addressed findings from the QA monitoring and tracking by the Nursing Department, most often to review reasons for G/J tube occlusions, dislodgement of tubes, etc. The minutes also included the establishment of a Corrective Action Plan (CAP) with action steps. The facility provided minutes from the 10/17/13 meeting where action plans were being put in place, such as additional competency based training/skills for nursing staff. The monitoring team could not ascertain the effectiveness of the actions because the committee had not had sufficient time to evaluate its own progress. The monitoring team will evaluate at the next monitoring visit. In the collection of data, the monitoring team suggests tracking by the number of days, for new tubes, dislodgement, occluded, etc. to ascertain if the problems with tubes were occurring more with new tubes versus existing tubes. Other QA activities, conducted by the QA Nurses, included completion of mortality summaries and tracking of mortality recommendations. The recommendations completion log showed that all recommendations were completed within 30 days of the implementation, for a death that occurred in May 2013. The monitoring team met with the QA nurse, and also reviewed the clinical death summary, associated records for Individual #115, and the mortality recommendations tracking log. During the record review, it was discovered that oxygen was administered. However, there was not a supporting physician order or policy in place for the administration of the oxygen. The facility had a 2/15/ 02 policy regarding Oxygen Administration. The policy did not, however, include physician emergency orders for the administration of oxygen. The monitoring team addressed this concern with the Program Compliance Nurse and CNE. They said that they planned to follow-up with the Medical Director to review the aforementioned issues specific to omissions of physician orders. The monitoring team will follow-up at the next visit as to the status of orders related to oxygen administration, specifically for urgent/emergent events, given each of the units has oxygen as part of their emergency response equipment. For more information regarding mortality reviews, please see section L. Nursing and QA conducted inter-rater reliability of audits. The reports showed adequate agreements for the percentages.	

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		In addition to the above quality assurance activities, the QA Nurse assured that the samples were randomly selected and of robust size, and that results from the audits were prepared in graph format. The graphs reviewed by the monitoring team included explanations as to downward or upward trends. The Compliance Nurse maintained a detailed tracking log that includes the number of tools required for an audit, the number completed, and verification that the number were completed. The log also included the name of the tool being monitored, the date, individual's record, problems identified, corrective action by individual nurse, and verification of the correction. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> The monitoring team attended several of the Clinical Morning meetings and reviewed the meeting minutes for 12/9/13 through 12/13/13. The meetings were held regularly and were well attended, however, there were problems in the presentation of the information. For example • Information presented weekly by the ICP, relevant to infections, was a verbal report, and no handouts were provided. o After discussion with the monitoring team, a document that provided a status report of individuals with current infections was to now be included as part of the Clinical Morning meeting documents. • Information contained on the Clinical Morning report appeared to be a written repetition of the 24 or 72 hours nursing log report. Often, there was a mixture of information related to internal operations, such as radio checks. • The information was not organized as to the individual, home, issue, actions taken, actions resolved, or the persons responsible. • The monitoring team was unable to discern which topics were current, ongoing, or resolved. MSSLC should consider restructure of the presentation agenda and documentation format. To move in the direction of substantial compliance, the monitoring team recommends that the Nursing Department/facility consider the following for focus/priority for the next six months: 1. The facility should ensure that its Clinical Morning meetings are fully integrated. Team members have access to written information during the meeting, such as infection control reports. In addition, a more user friendly format that tracks each individual's acute changes in status, and their associated problems to resolution was needed. 2. The facility should continue its positive efforts in the reduction of infections, and ensure there is cooperation and collaboration regarding resolving identification of care issues identified by the facility. 3. The CNE and nursing leadership staff should continue their positive efforts in the	

#	Provision	Assessment of Status	Compliance
		hiring and retaining of sufficient and proficient staff. The CNE should work with facility administration regarding recruitment or recruitment processes.	
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 RN Case Manager Supervisor continued to ensure that all individuals who resided at MSSLC had an assigned RN Case Manager, and that their RN Case Manager was sufficiently trained to advocate and assist in the coordination of the individual's health/mental health care. During an interview with the RN Case Manager Supervisor, her commitment was evidenced by the many plans that were put in place to assure consistency among the RN Case Managers, including in their assessments. Since the last compliance visit, the RN Case Manager Supervisor: • Developed, as recommended by the monitoring team, Guidelines for Completing the Nursing Discharge Summaries. • Developed and implemented a tool for auditing the revised Nursing Assessments and the IHP, both of which had since been forwarded to the state office Nursing Coordinator for her review. Currently, the facility was using the tool to measure the effectiveness of their nursing assessments and the IHCP. • Continued to maintain a detailed database that tracked all nursing assessments, ISPs, IHCPs, and annual and quarterly assessments due dates. • Was fortunate to have an assigned RN Case Manager to assist in providing one-to-one mentoring of staff. Nursing assessments/quarterlies were reviewed by the mentor prior to submission to the QIDP. The RN Case Manager received feedback regarding needed improvement to assessments. The monitoring team observed RN Case Managers on the units while they engaged with the individuals, during ISP meetings, and during a CLDP meeting. <u>New/Revised Policies, Procedures, Processes, Protocols:</u> • DADS Guidelines: Comprehensive Nursing Review/Quarterly Record Review/Quarterly Physical Assessment, 4/13 • DADS Guidelines: Nursing Services Policy #010.3, effective 6/17/13 • DADS SSLC Nursing Service Comprehensive Nursing Review Standardized Format, dated: 9/30/13 • MSSLC Discharge Summary Guidelines 9/13 • Universal Compliance Monitoring Tool (RN Case Management Meal Time Monitoring/Medication Monitoring) • Home Life and Training – Meal Observation Sheet • Section M. Nursing Care Plans Monitoring Tool/Instructions • MSSLC Section M Annual Nursing Review/Physical Assessment Tool/Instructions 10/25/13	Noncompliance

#	Provision	Assessment of Status	Compliance
		• MSSLC MOSES/DISCUS/AVATAR process by RN Case Managers 9/25/13 • MSSLC Discharge Summary Guidelines 9/15/13 • MSSLC Documentation of Nursing Discharge Summary Review 10/1/13 <u>Training</u> • 28 of 28 (100%) RN Case Managers completed the state's mandated training Physical Assessment, Skills Competencies • 28 of 28 (100%) RN Case Managers completed the Risk Training for the IRRF and IHCP • 28 of 28 (100%) RN Case Manager have completed the states mandatory trainings, and annual skills competency • 28 of 28 (100%) had been trained in the risk process The monitoring team reviewed the most recently completed Annual and/or quarterly Comprehensive Nursing Assessments of a sample selected from the facility's At Risk List and one from each unit: Individual #17, Individual #331, Individual #273, Individual #43, Individual #31, Individual #567, Individual #160, Individual #407, Individual #779, Individual #468, and Individual #934. The monitoring team used the tool developed by MSSLC for reviewing Annual/Quarterly Comprehensive Nursing Assessments. • 21 of 25 (84%) of the most recently completed Annual, and/or quarterly Comprehensive Nursing Assessments were completed timely in accordance with facility policy. This was in the range of the facility's findings for timeliness. • 25 of the last completed Annual and/or quarterly Comprehensive Nursing Assessments were reviewed for an overall score of 85%. • The most problematic aspect was the nursing summaries, which were deficient in that the summaries did not consistently qualify, for every problem/diagnosis, the data, by indicating progress toward the stated goals or the effectiveness of the health care plan. In addition, there continued to be documentation that individuals would not experience any untoward effects as a result of their health conditions problems. For example, most statements were for the individual to be "free" or have "no" episodes related to their health conditions, such as seizures. The monitoring team also reviewed the following ER/LTAC Hospital Nursing Assessments Reports for six hospitalizations occurring 9/25/13 through 11/25/13 for Individual #160, Individual #407, and Individual #567. The findings provided: • Three of three (100%) were assessed without delay upon their return; all were assessed within 30 minutes of their arrival back to the facility. • Three of three (100%) reports contained the reason for the hospitalization and admission. • Three of three (100%) reports contained documentation of full vital signs.	

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		• Three of three (100%) reports had documentation of a physical assessment and review of systems. • Two of three (66%) included sufficient specific instructions that the RN communicated to other team members about the changes in the individual's condition. • One of three (33%) contained a signature of review by the RN Case Manager To move toward compliance in the next six months, the Nursing Department should ensure, when auditing the quarterly and annual nursing assessments, that the audit reflects a measure of quality, not just that an item was present in the document. The RN Case Manager Supervisor should continue her positive efforts toward improvements in the Annual/Quarterly Comprehensive Assessments, through training/education/remediation and through one-to-one over-the-shoulder mentoring. The RN Case Manager Supervisor should also review the ER/LTAC Hospital Nursing Reports, as what the expected role of the RN Case Manager is, beyond signing on the provided structured signature block for RN Case Managers. Although the monitoring team found assessments to have improved in the timeliness, regrettably, more time is needed to improve upon the quality/content of the Annual/Quarterly nursing assessments, therefore, the provision was not found in compliance.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	The facility rated this provision in noncompliance based on "overall care plan upkeep still needs improvements with revising and resolving health care issues." The monitoring team was in agreement with the facility's assessment. The monitoring team reviewed Acute Care Plans and associated IPNs for Individual #31, Individual #567, Individual #779, and Individual #43. Findings from the review included: • Two of five (40%) generic plans were modified sufficiently to assess and monitor the individual's health condition • Four of five (80%) plans had baseline data that sufficiently described the issue for the implementation of a health care plan • Three of five (60%) plans had goals sufficient to identify the desired outcomes for their acute illness/injury • Four of five (80%) plans included that the Direct Support Professional (DSP) was trained on the health care plan • Four of five (80%) were initiated promptly upon the identification of the problem • Four of five (80%) had written instructions that could easily be understood by the DSP for reporting changes	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Four of five (80%) of the plans when initiated were documented in the IPN • Three of five (60%) plans were individualized • Four of five (80%) of the plans included relevant preventative measures • Four of five (80%) of the plans included measurable nursing interventions • Three of five (60%) plans were reviewed/ and or revised as indicated by a change in condition the revision or resolved plan as applicable to the health issue o Individual #424's health care plan was for folliculitis left upper lip. After being evaluated at the hospital, a diagnosis was given for cellulitis. He should have had a new nursing care plan that addressed cellulitis. o Individual #567's IPN notes were reviewed for the period of 12/1/13 through 12/11/13, which documented several skin integrity issues occurring during the period (e.g., open sore on right leg, abrasion to mid back) and that he pulled off his left middle fingernail on 12/10/13. The monitoring team did not locate a care plan for the skin integrity issues. The IPN notes were found that sufficiently described the problem and included nursing interventions, as well as instructions to the DSP to manage and monitor the identified health problem. <u>Community Discharge Planning/Community Discharge Summaries</u> The monitoring team attended a CLDP meeting for Individual #406 on 12/11/13 and found: • All relevant IDT staff and the individual were in attendance; reportedly the individual's assigned RN Case Manager had two meetings at the same time, thus a different RN Case Manager designee filled the role. • During the meeting, pertinent health questions arose regarding the individual's diabetic status. Disappointedly, the RN Case Manager was not well informed. The RN Case Manager should have been more familiar with the individual's current medical treatment plan, including medications, in order to assist the team to make appropriate determinations for health care. • During the meeting, the Compliance Nurse had to provide prompts to the RN Case Manager to ensure she addressed the individual in terms that he could understand (e.g., podiatrist as foot doctor). • During the meeting, it was also discovered the individual may not have all of his necessary supports, such as ear plugs. • The individual was presented with opportunities toward his likes and dislikes. • There was consensus on recommendation by the IDT to include move date for the individual for 12/30/13. • Both the IRRF and IHCP contained in the record for both the Diabetes and Behavior risk did not contain information regarding contributing antecedents for his aggression (i.e., behavior risk). It was also troublesome to find the IHCP was	

#	Provision	Assessment of Status	Compliance
		not individualized for the individual. For example, under Psychotropic IHCP, there were canned statements that referred to menstrual irregularities and hot flashes (not applicable to the individual who was male). The facility's state nursing policy states that the "nurse will collaborate with other members of the IDT to develop an IHCP with individualized goals and interventions that meet the individual's needs" and that "the IHCP will include interventions for specific side effect monitoring by staff and will reference behavioral interventions outline in the Behavior Plan." • After the meeting the monitoring team met with the RN Case Manager who attended the CDLP, the assigned RN Case Manager, and the Compliance Officer. The individual's assigned RN Case Manager displayed a very caring attitude toward the individual and was notably very knowledgeable about the individual's likes, dislikes, current medication regimen, and recent issues related to elevated blood sugars and incidents of aggression. Since the last monitoring visit the RN Case Manager had developed guidelines for completing the Nursing Discharge Summary and a monitoring tool for measuring Documentation of the Nursing Discharge Summaries. The monitoring team reviewed five discharge summaries utilizing the MSSLC newly developed tool for documentation as applicable for Individual #335, Individual #253, Individual #236, Individual #305, and Individual #698 and found: • Five of five (100%) contained the RN name, title, and date • Five of five (100%) documented the current medication list, last MOSES/DISCUS, any acute NCP, Current Immunization Records, and IRRF/IHCP marked as attached. One of the five noted the individual was awaiting consent to administer Hepatitis vaccine of which the status of the consent was not provided • Five of five (100%) of the individuals' recent consults were documented • Four of five (80%) provided sufficient information regarding the abnormal labs • Four of five (80%) identified and discussed the individual's weight issues • Three of five (60%) contained information regarding whether/how the individual participated in his/her own care The monitoring team's findings were similar to the facility's findings using the facility's new form for auditing Documentation of Nursing Discharge Summary Review. Overall, there was improvement in documentation. The Nursing Discharge Summaries were improved from the previous Nursing Discharge Summaries. The RN Case Manager Supervisor, in response to the monitoring team's previous report recommendation, is credited in the development of guidelines for completing the Nursing Discharge Summaries.	

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		Another positive example showed improved documentation of the individual's significant health problems. They were written in terms that could be easily understood, to identify and report changes in the individual's health conditions. However, some areas remained problematic. For example; a number of the Nursing Discharge Summaries contained statements that individuals would not experience any untoward effects as a result of their health conditions. The Nursing Department reported the newly developed guidelines and tool were sent to the State Officer for review and recommendations. To move toward compliance, the Nursing department should continue to provide processes that assist nurses to develop individualized care plans, and to monitor, revise, and resolve health care plans, as appropriate.	
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.	<u>New/Revised State/Local Policies, Procedures, Processes and Protocols:</u> • DADS Nursing Services Policy #010.3, effective 6/17/13 • DADS Medication Administration Guidelines, Date: 6/13 • DADS Protocol Cards 8/13: falls, suspected fracture, hypoglycemia, emergency and hospital transfers <u>Training Activities:</u> • The monitoring team interviewed the Nurse Educator and reviewed the facility's Section M.4. Presentation Book, Nursing Training Database, and competency based training materials and records. In addition the monitor reviewed the self-assessment and the Nurse Educator's calendar that provided the monthly schedule for the state's mandated competencies. • The Nurse Educator adhered to the instructions outlined in the Nurse Educator's Handbook and as required by the Nursing Competency Based Training Policy. • Trainings included didactic classroom sessions as well as over the shoulder return demonstrations when applicable. All of the training was competency based. The annual competency training was also used for new nurse orientation. • The Nurse Educator set up systems so that nurses can go online to sign up for classes on the calendar. After selecting the class, the nurse's name appeared in the block. • The Nurse Educators maintained a detailed database that included each nurse and the status of his/her education. Below is a chart that provided the status of the Nursing Annual Competency completed as of 11/13.	Substantial Compliance

#	Provision	Assessment of Status			Compliance
		Annual Competencies as required by Competency Based Training Policy	Training Date	Percentage Trained	
		Mosby Chapters			
		Chest/ Abdomen	11/12	100%	
		Skin – Musculoskeletal	2/13	100%	
		Heart/Neurological	5/13	100%	
		Eyes/Head neck	5/13	100%	
		Pain/Breasts/Mental Status	10/13	100%	
		Acute Illness and injury	12/12	100%	
		Care Plan Development	12/12	99%	
		Disability Rights	12/12	100%	
		DISCUS/MOSES Screen TD	2/12	100%	
		Hospital, Transfers, and Discharges	1/13	100%	
		Medication Administration	12/12	100%	
		Medication Observation	12/12	100%	
		Medication Side Effects	12/12	100%	
		Neuro Asses Test	12/12	100%	
		PICA	9/13	99%	
		POST Anesthesia Care	12/12	100%	
		Restraints	12/12	100%	
		Risk Process	12/12	100%	
		Seizure Management Care	12/12	100%	
		SAM on the Home	5/13	100%	
		SOAP Documentation	4/13	100%	
		Nurse Competency Skills Fair	Annual Scheduled 2/14		
		Diastat	1/13	100%	
		G/J tube Stoma Care Medication Administration	1/13	100%	
		Foley/Supra Pubic Cath	1/13	100%	
		Glucometer Use	1/13	100%	
		Hemoccult	1/13	100%	
		Injection Protocol	1/13	100%	
		*N/G Tube Care	1/13	100%	
		Plac-Vac Suction	1/13	100%	
		Trach Care	1/13	100%	
		Trach Suction	1/13	100%	
		Trach Dislodge	1/13	100%	
		Urinary Catheter (male and female)	1/13	100%	
		Urine Dipstick	1/13	100%	
		Vital Signs	1/13	100%	

#	Provision	Assessment of Status	Compliance

Wound Care Management	1/13	100%
Medication Administration Position Nursing	1/13	100%
Injury Report Checklist	1/13	100%
Med Pass Observation OJT	1/13	100%

In addition to the above table, the monitoring team reviewed the nurse educator's documentation of training of the 23 Nursing Protocol cards conducted. 100% of the nursing staff was trained on all 23 nursing protocol cards. Nursing Protocol cards were integrated into the new orientation processes for all nurses as well as into refresher training. The monitoring team determined this by reviewing the training curriculum and interviewing the Nurse Educator.

At the next compliance visit the monitoring team will review the databases for the annual competencies scheduled for 2/14, as well as review records for new hires.

The monitoring team, during rounds on the units at various times of the day and evening, found that all of the 52 nurses encountered were carrying the full set of protocol cards on their person as required.

The monitoring team randomly interviewed 15 of these nurses and posed questions with regard to how they accessed certain presenting conditions. Every one of these nurses responded to the monitoring team's questions with appropriate and correct answers. One example was regarding a head injury. The nurse who responded, used the nursing process, to verbally walk through the steps in the protocol.

Below are the results from the Nursing Department's own data set regarding Nursing Protocol card Audits from June 2013 through November 2013 for eight protocols chosen by the facility.

Protocol	Jun.	July	Aug.	Sept.	Oct.	Nov.	Overall
Pain	86%	72%	91%	72%	81%	92%	82.33%
Vomiting	95%	86%	100%	83%	80%	79%	87%
Head injury	79%	94%	88%	82%	65%	93%	84%
Post Sedation	66%	100%	87%	100%	100%	94%	91%

#	Provision	Assessment of Status	Compliance

Constipation	90%	97%	98%	94%	82%	81%	90 %
Antibiotic	87%	92%	95%	82%	89%	89%	89%
Seizure	91%	89%	89%	92%	95%	75%	89%
UTI (estimated)	n.a.	78%	55%	82%	87%	n.a.	

The overall average for of these protocol cards was calculated by the facility to be 85%.

The monitoring team reviewed a sample of records selected from the facility's At Risk List for individuals identified with high risk health conditions for each unit for Individual #17, Individual #331, Individual #273, Individual #43, Individual #31, Individual #567, Individual #160, Individual #407, Individual #779, Individual #468, and Individual #934. The monitoring team randomly selected five records from the list of 11 above examples found in the records where the protocols were followed. The review found five of five (100%) occurrences of an acute event followed the nursing protocols and, as applicable, there was an appropriate acute health care plan and/or an IHCP. Of these five, there was an acute care plan for one (Individual #407). The interventions in the acute care plan were consistent with the interventions in the nursing protocols. Of these five, there was an IHCP for three related to the acute occurrences reviewed by the monitoring team (Individual #407, Individual #331, Individual #31). The interventions in the IHCP were consistent with the interventions in the nursing protocols.

- On 10/2/13, 9:20 am, Individual #779 reported that he had a headache (he called it a migraine). The individual was administered pain medication. The Nursing Protocols for Pain were promptly initiated, including using the Wong-Baker-Face-Scale to access level of pain. The IPN notes documented that the protocol was followed, and included a statement that the headache was relieved by the medication. Resolution of the headache was documented in the IPN on 10/2/13 at 5:50 pm.
- On 9/8/13 at 10:15 pm, Individual #31's staff reported to the nurse that the individual had a seizure. The Nursing Protocol for Seizure disorder was implemented. The IPN notes documented that the seizure protocol was followed. Resolution of the seizure was documented on the IPN note on 9/9/13 at 10:00 am. Individual #31's IRRF rated the individual as high risk for seizures. The IHCP contained interventions for seizures, including the daily monitoring of any antecedents (i.e., triggers).
- On 10/1/13 at 5:20 pm, Individual #468 complained of a "headache and stuffy head." The nurse initiated the Pain Protocol and Minimum Documentation

#	Provision	Assessment of Status	Compliance
		Standards. The individual was followed in accordance with the protocol to resolution. The resolution was documented in the IPN note on 10/3/13 at 5:15 pm. • On 9/16/13 at 12:30 pm, Individual #331's record documented "bit his right arm." The nurse implemented both the Pain protocol and Minimum Documentation Standards. The area was documented as having "no skin breakage." An IPN note described the area as to the healing progress and size, location, and the individual's pain. This was documented daily. The date of the IPN resolution note was 9/20/13 at 3:30 pm. Individual #331's IHCP included monitoring skin care and reporting any changes in skin integrity daily. • On 10/5/13 at 7:30 am, Individual #407's DSP reported the individual had "cyst," that was located in his pubic area. The Minimum Standards Documentation and Pain protocols were promptly implemented. The individual was referred and seen by a physician on10/6/13 and prescribed an antibiotic for the diagnosis of an abscess. The Antibiotic protocol was implemented on 10/6/13. The individual received follow-up by the physician on 10/9/13 as a result of, and in response to, the assessments by the nurses for the abscess. The physician prescribed an antibiotic for five days. On 10/9/13 at 7:30 pm, the DSP called for the nurse. The individual had vomited. The Vomiting protocol was put in place, and there was notification to two physicians. Both the nursing protocols for antibiotic therapy and vomiting were consistently followed and documented in the IPN. The resolution of the Antibiotic therapy was documented in accordance with the protocol. Both the Minimum Standards Documentation and Vomiting protocols continued regarding skin integrity related to the "abscess, boil" and the ongoing episodic occurrences of vomiting through 11/25/13; these were documented in the IPN. On 11/25/13, the individual was transferred to the hospital. Individual #407's IHCP included proactive and preventive interventions for monitoring and reporting related to aspiration. For example, the reporting of any vomiting to the PCP, observation of residuals, and elevation of the HOB. The IHCP also included the monitoring of fluids, skin integrity, and infections, including the daily monitoring of antecedents, triggers, bowel records, etc. The monitoring team's review found all Nursing Protocols were consistently followed, including documentation of Minimum Standards, and application of nursing process in conducting nursing assessments, including applicable systems review and vital signs for the affected area or specific complaint. Consistently, the identified problems were followed up to resolution and, as appropriate to the problem, contained an applicable acute care plan. For this sample of 5, interventions in the IHCP for these risk areas were in line with the interventions in the Nursing Protocols. The IPNs and other documents indicated routine implementation of these protocols.	

#	Provision	Assessment of Status	Compliance
		Throughout the monitoring team's review of this provision, via observation, interview, and document review, it was evident that the required training and policies, procedures, and processes were being implemented and monitored. The monitoring team is in agreement with the facility's self-assessment of substantial compliance.	
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's self-assessment stated noncompliance because the data were inadequate to make determinations of overall quality that reflected the IDT's discussion of risk and identifying risk appropriately. The monitoring team agreed with the self-assessment. The monitoring team attended one ISP meeting, which was held on behalf of Individual #331 and found: • All relevant IDT members, the individual, and the individual's school advisor were in attendance at the meeting. • The QIDP conducted a very effective meeting by beginning with introductions and providing, at every part of the review and discussion, opportunities for the individual to participate in his ISP, which he did. • One of the most positive contributions was a letter from the school that was read aloud, commenting on the many positive goals the individual had accomplished, goals associated with his PBSP. • Notably, there was some improvement in the IRRF and IHCP process. The RN Case Manager was well prepared for the meeting and able to provide information when the IDT had questions. The RN Case Manager, when responding, spoke in person-centered terms when referring to or addressing the individual's health and mental health issues, and ensured he was in agreement by speaking directly with him. • The RN Case Manager reported that the individual's previous rating for behavioral was high. The team had a discussion that included progress the individual had made, and the team was in agreement that the rating could be downgraded to medium, due to the amount of progress the individual had sustained over the past year. • For each risk discussion topic, the IDT members were in agreement, and the RN Case Manager and IDT also ensured the individual understood what his risk was, and how he could participate in minimizing the identified risk. The risk rating form for cardiac disease documented the individual hand an EKG in October 2013, which showed sinus bradycardia. This was clarified during the meeting by the psychologist, who reported this was due to a medication, Inderal, which had been discontinued. • The QIDP did an excellent job of guiding the meeting. It was a positive and productive ISP meeting. • After a review of all of the documents after the review, the risk rating appeared appropriate.	Noncompliance

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		• Rather than applying principles of critical thinking, however, the facility appeared to rely, for the most part, on the guidance items/questions listed on the IRRF . • RN Case Manager was well prepared for the meeting, and when question by the IDT was readily able to provide the information. The monitoring team reviewed, for 11 records selected in the sample, the Integrated Risk Forms and Integrated Heath Care Plan forms. These were for Individual #17, Individual #331, Individual #273, Individual #43, Individual #31, Individual #567, Individual #160, Individual #407, Individual #779, Individual #468, and Individual #934. The monitoring team found: • Two of two (100%) individuals had a change of status IRRF. Of the two, both contained a COS IHCP, and one COS IRRF, was located in the submitted record. • Nine of 11 (81%) contained preventive measures to lessen the identified risk ratings • Eight of 11 (81%) were sufficiently integrated among disciplines • Eight of 11 (81%) contained functional and measurable objectives in the ISP to measure efficacy of the plans, although most were not specific to the risk ratings and the individuals • Eight of 11 (73%) had sufficient nursing assessments to assist the team in developing appropriate plans to meet the individuals health care needs • Eleven of 11 (100%) IHCPs were developed and implemented with the 14 days, however, from all the identified risk ratings, it was difficult to discern that all plans had been implemented For all of the 11 records reviewed, all had one or more "high" risks related to health/mental health, where their risk were not always appropriately and clinically correlated based on their identified health problems or potential health problems. In some cases, it appeared the risk was driven by whether or not the individual actually had an incident and/or a negative outcome from the incident. Examples included the following: • On 7/30/13, Individual #407's team agreed that his history of choking was low. The information the team used to determine risk appeared to be the same information that was used to consider a change of status elevating the choking risk to medium after reconsideration by the team on 11/12/13, specifically his NPO status. However, it did not appear that the current rationale for the NPO rating was fully considered during the 7/30/13 IDT meeting. The COS IRRF noted that the rationale for the rating was due to risk associated with the NPO status, including a concern that someone who did not know the individual was NPO and provided oral foods would place the individual at a greater level of risk for choking.	

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		• On 12/12/12 Individual #160's team agreed that she was high risk for seizures and low risk for aspiration. Over the course of subsequent months, the individual experienced episodic vomiting and seizures. The record further contained documentation by the RN that, during the MRC on 11/13/13, the "physician felt this could be aspiration pneumonia." Although ISPAs were held, none resulted in a COS to re-assess risk. On 12/11/13, when the team met for the individual's annual staffing, changes were made to risk for aspiration. An important outcome from the IDT, IRRF and the IHCP is to guide the provision of health care/mental health supports and surveillance for the individual, based on the identified individual risks. To move toward compliance the facility should ensure there are ongoing training opportunities and oversight that ensure consistency across all IDTs, as well as among disciplines regarding IRRFs and IHCPs. The facility should consider interdisciplinary training that focuses on the aspects of critical thinking.	
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.	<u>Medication Oversight and Monitoring</u> MSSLC continued to build upon and improve their existing systems to prevent harm to their residents due to medication administration errors. The facility continued to have in place an integrated interdisciplinary system for: • Reviewing actual and potential medication errors that occurred, and investigation of the contributing causes of errors with the objective of identifying ways to improve the medication safety system to prevent future errors and potential harm to individuals. • Formal committees (Medication Error Review Committee (MERC), Pharmacy and Therapeutics Committees) where there was an open forum of disciplines, new ideas were welcomed, accountability was owned, and discussion occurred regarding investigations, review of medication safety issues, and development of plans of action to address those issues. • Effective orientation and ongoing training, combined with constructive performance assessments • Reconciling medications at multiple points in the care process • Quality assurance/self-assessment process for measuring progress, or lack of progress • Ongoing safety-improvement activities, including environmental. For example, (new) magnifiers and improvements to the lighting in medication administration areas • Communication process across all levels that ensure lessons learned are fed back into practice, for example, weekly nursing focus meetings	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		During the week of the onsite review, the monitoring team attended the meeting of the Medication Error Committee, which was chaired by the Chief Nurse Executive. The meeting was attended by Medical, Dental, Pharmacy, Quality Assurance RNs, and representation of Nursing leadership for their respective unit. The agenda/meeting format was much improved and provided valuable information to assist the committee to track disposition/corrective actions related to the topics, and the status of those actions. During the review the committee presented and discussed its historical medication data. The data were presented in graphs, which contained correlating information associated with the variances, such as discipline, shift, location, type, and severity index. The information was extensive, meaningful, tracked, documented, examined, interpreted, and reported routinely. The facility also tracked to resolution its interventions and corrective actions to prevent medication variances. The following are the issues raised by the committee during the meeting for continued planning and intervening to improve upon the facility's practices and procedures surrounding medication administration: • Clarify primary care orders for medication variances that required intervention, (i.e., monitoring) • Ensure there is a review team process that is discipline specific when assigning the severity of risk. The above initiatives were pending further review and implementation by the committee and/or their designees. The monitoring team will follow-up at the next monitoring visit. The monitoring team obtained clarification, as noted from the previous report, of the medication verification process by two nurses, which included initials by each nurse on the MAR, implemented in 5/13. The facility's M6 action plan from 8/8/13 through 10/15/13 "real time" audits showed 20 of 24 (83%) compliances with the verification process (i.e., it was followed correctly). The facility also documented providing remedial training and re-inserviced all nurses in 8/13. The monitoring team will follow-up at the next visit as the facility has not had enough time to see the effectiveness of the process. MSSLC's Nursing Department, for the period of 6/13 through 10/13, conducted 200 reviews of nurses' administrations of medications per month, using the state's revised medication variance form. Any nurse scoring below 100% received remedial education, or immediate prompting at the time of the pass. The remediation was conducted by the RN Nurse Managers, and documentation of the remediation was tracked to resolution by the Nurse Educator.	

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		Medication Administration Training • Mandated Medication Administration Positioning for Nurses (100%) nurses trained Monitoring Team's Medication Administration Observations The monitoring team conducted unscheduled medication observations on all the units, at various times of the day for 15 different individuals. The monitoring team was accompanied by the Nursing Compliance Officer and the NOO. The monitoring team observations also included the application facility's Medication Observation Audit tool for those items weighted as "essential." The findings are as follows: • 15 of 15 (100%) of the observations were compliant with the applicable essential items • For each medication pass observation the monitoring team observed: o interaction between the individual, direct support staff, and the nurse administering the medication o identification of the individual was completed with staff o individuals, engaged in hand hygiene practices prior to receiving their medications o nurses consistently adhered to infection control standards • The nurses administered medications, oral and eternal, following generally accepted professional standards of safe medication practices • The nurses consistently prior to administration, reviewed the individual's allergies and PNMPs. • The nurses ensured the individuals receiving oral medications had swallowed their medications. • For the individuals who had approved Self-Administration of Medication Programs (SAMs), it was evident there was ongoing participation by the individual, through their responses about their medications, with little or no prompts by the nurse. • It was positive to observe, when individual #273 presented for his medications, the nurse also inquired about the individual pain level, given his health conditions and the fact he was described as being very stoic about talking to anyone about his pain. The nurse conducted a complete pain assessment prior to administering the pain medication, and informed the individual she would follow-up to see if the pain medication had helped. • The nurses ensured that the carts, liquid medication bottles, and other tools, such as the pill crusher, were properly cleaned between uses. • The nurses ensured each individual's preferences were acknowledged and adhered to. • During some of the observations, the nurses did not provide the direct support	

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		professional/individual with instructions specific to medication side effects, of which they were immediately prompted. <u>Documentation</u> • 15 of 15 (100%) Medication Administration Records documented medications administrated for all the observed medications passes were documented on the MAR record. • 15 of 15 (100%) MARs 12/1/13 through 12/11/13 did not contain omissions (blanks) • Seven of seven (100%) of the SAMs Program contained documentation that the questions on the SAMs program for the individual were rotated on the shifts as recommended. <u>Storage</u> • Controlled substances were observed as doubly secured and accounted for by nurses, in accordance with medication logs. • Focused reviews for storage found all medications with current expiration dates, opened medications were dated, and stored appropriately in accordance with accepted standards of practice. <u>Medication Variance Reports</u> The monitoring team's reviewed of the MSSLC's 10 most recently completed Medication Variance Reports for Individual #31, Individual #38, Individual #188, Individual #456, Individual #261, Individual #105, Individual #285, Individual #185, and Individual #657, Individual #790 found: • 10 of 10 (100%) reports were completed. Each of the reports indicated the type of a variance, severity index, and physician notification. Each of the reports appropriate to nursing, were reviewed by nursing supervision, and contained actions taken for remediation of the variance.. • 9 of 10 (90%) reports correctly rated the severity index. <u>Pharmacy and Therapeutics Committee</u> The monitoring team reviewed the last six months of the Pharmacy and Therapeutics Committee where the committee had met once since the last monitoring visit. The 9/30/13 agenda alluded to Nursing: Medication Variance, and Infection Control, however, the minutes did not include any new data regarding Medication Variances. See section N8 for more information. The monitoring team reviewed the document submission, audit reports, medication pass observation forms and reports, months of medication variance data, and meeting minutes;	

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		interviewed nurses and nursing leadership; and attended meetings and observed onsite medication administration practices. The monitoring team concluded that there was evidence that systems and processes continued to be in place to store, deliver, administer, and account for medications, including medication variances, in accordance with generally accepted professional standards of medication safety practice. The monitoring team agreed with the facility's self-assessment that the facility had maintained substantial compliance.	

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 MSSLC Policy and Procedure Medical #31, Drug Utilization Evaluation, 8/16/12 o MSSLC Policy and Procedure Medical #29, Quarterly Drug Regimen Review, 1/10/13 o MSSLC Policy and Procedure Medical #30, Adverse Drug Reactions, 1/10/13 o MSSLC Policy and Procedure Medical #23, Monitoring Clozapine, 9//26/13 o MSSLC Policy and Procedure, Medical Services - 25- Safe Medication Practices, 9/11/12 o MSSLC Policy and Procedure: MOSES and DISCUS Screening, Nursing Services o Pharmacy and Therapeutics Committee Meeting Minutes o Medication Variance Review Committee Meeting Notes o Polypharmacy Committee Meeting Minutes 2013 o Clinical Interventions Reports May 2013 – October 2013 o Review of Physician Orders Reports, o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations • Lithium • Bisphosphonates o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #505, Individual #365, Individual #227, Individual #475, Individual #595, Individual #276, Individual #556, Individual #589, Individual #483, Individual #105, Individual #211, Individual #918, Individual #415, Individual #619, Individual #457, Individual #43, Individual #285, Individual #160, Individual #867, Individual #917 Individual #456 Individual #43, Individual #492, Individual #595, Individual #470, Individual #892, Individual #850, Individual #432, Individual #185, Individual #120, Individual #235, Individual #15, Individual #593, Individual #468, Individual #529, Individual #9, Individual #698, Individual #990

	o MOSES and/or DISCUS Evaluations for the following individuals • Individual #631, Individual #157, Individual #698, Individual #875, Individual #225 Individual #782, Individual #972, Individual #790, Individual #592, Individual #556, Individual #209, Individual #224, Individual #475, Individual #990, Individual #619, Individual #366, Individual #64, Individual #752Individual #109, Individual #10, Individual #600, Individual #99, Individual #502, Individual #119, Individual #202 Individual #257, Individual #540, Individual #427, Individual #492, Individual #595, Individual #470, Individual #160, Individual #43 , Individual #285, Individual #867, Individual #917, Individual #456, Individual #892 <u>Interviews and Meetings Held</u>: 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 Joan McClary, MD, Primary Care Physician o James E. Garza MD, Primary Care Physician o Kendall Brown MD, Staff Psychiatrist o Madhu Rao MD, Staff Psychiatrist o Juanita Kirby, MD, Staff Psychiatrist o Angela Johnson, RN, Medical Compliance Nurse o Norris Buchmeyer, Chief Nurse Executive o Karen Wilson RN, QA Nurse <u>Observations Conducted</u>: 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 facility lead listed the activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. For N1 the facility lead reviewed: (1) a sample of physician orders to ensure “pharmacist communicated

	with medical staff" in regards to interactions, side effects, etc., (2) a sample of drug interactions to determine if there was proper documentation, (3) clozapine monitoring, and (4) the Intelligent Alerts report. The self-assessment reported compliance rates of 99.5%, 100%, 91%, and 100, respectively for these audits. Based on this self- assessment a self-rating of substantial compliance was given. The monitoring team, however, found many of the items in the self-assessment did not accurately reflect the areas measured by the monitoring team. For example, for N2, state office provided a definition of a timely assessment. QDRRs must be completed within a specified 21-day window timeframe to be considered timely. Completion outside of the window was not timely. However, the self-rating was not based on that definition, but it should be. Provision item N4 addresses the providers' responses to recommendations of the pharmacists. The self-assessment only addressed the retrospective recommendations, even though last compliance report noted that prospective and retrospective recommendations needed to be addressed. As has been noted in previous reports, the facility lead must read the entire report, taking note of the comments and recommendations. In addition to measuring areas deemed important by the facility, the self-assessment should also include an assessment of areas measured by the monitoring team using similar metrics.
	Summary of Monitor's Assessment: There was no significant progress in the provision of pharmacy services. For the most part, most practices were maintained. Some slight gains were made by improving the timelines in the completion of the QDRRs. The pharmacists continued to document communication with prescribers, but there were problems with some communication, particularly when severe drug interactions were involved. Physicians frequently elected to reject the recommendations, including those related to drug interactions and there was no clear documentation of the clinical justification. Prospective lab monitoring continued to present challenges at MSSLC. The Intelligent Alerts were implemented, however, again, physicians often elected to reject the monitoring and facility reports did not accurately reflect the monitoring that was occurring. There was improvement in timely completion of the QDRRs, but some were now completed ahead of schedule. State guidelines provided a 21-day window for completion of QDRRs. Overall, the content was adequate, but additional work was needed in monitoring for the metabolic syndrome. Providers were rejecting a significant number of prospective recommendations. Retrospective recommendations appeared to be accepted, but QDRRs were not submitted for all providers. The monitoring team has consistently stated that recommendations apply to <u>prospective and retrospective</u> recommendations. The facility should address this through the corrective action plans of the external medical reviews.

	The MOSES and DISCUS evaluations continued to present numerous challenges. The evaluations were completed electronically and were being improperly executed. Adverse drugs reactions were reported and it was good to see that this was occurring. The medical director needs to explore the relationship between the ADRs and other problems, such as lab monitoring and drug interactions, etc. The DUEs were occurring as required. The medication variance program remained in place. There were continued efforts to collect and analyze data and use the data to implement corrective actions. There were significant concerns, however, about the accuracy of the data based on the how the variances were being categorized. There was also some evidence that the system was not functioning as a truly multidisciplinary program.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.</td><td>This provision item is related to fundamental components of the medication use system – the prescribing and dispensing of medications. The pharmacy department completed prospective reviews for all new orders through the WORx software program. The program checked a number of parameters, such as therapeutic duplication, drug interactions, allergies, and other issues. Clinical interventions and review of physician orders continued to be documented by the pharmacy department. The facility tracked data related to the number of prospective reviews. Summary data are presented in the chart below.

<table>
<tr><td colspan="7">Prospective Order Review Data 2013</td></tr>
<tr><td></td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td></tr>
<tr><td>No. of Clinical Interventions</td><td>25</td><td>31</td><td>28</td><td>31</td><td>29</td><td>33</td></tr>
<tr><td>No. of Review of Orders</td><td>19</td><td>21</td><td>12</td><td>19</td><td>16</td><td>16</td></tr>
</table>

The number of interactions reported each month was relatively consistent. The monitoring team reviewed the Clinical Intervention and Review of Physician Order forms submitted by the facility. The summary logs for the current review period were not submitted. The clinical intervention forms documented several types of recommendations made to the prescribers, the responses of the prescribers, and the outcomes. Recommendations were frequently made regarding therapeutic duplication, avoidance of ADRs, drug interactions, and lab monitoring. The following are a few examples of the types of interventions documented on the forms:
• 5/6/13: Clinical intervention related to severe DDI. The prescriber was notified by phone. The recommendation was declined and justified. There were no changes made to the medication order.
• 5/7/13: Clinical intervention related to a severe DDI with lithium and Lisinopril. The prescriber was notified by phone. No changes were needed, but follow-up was required.
• 5/28/13: Clinical intervention related to laboratory monitoring for Divalproex. A</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		CBC was needed. The prescriber made no changes, but follow-up was needed. • 5/30/13: Clinical intervention related to a supra-therapeutic dose of Seroquel (1000 mg/day). The prescriber was contacted and the recommendation was declined. There were no changes made and the active records showed no documentation of the justification for continuation of the dose and rejection of the recommendation of the pharmacist. • 6/24/13: Clinical intervention for the prescribing of Zyvox and Citalopram, which are contraindicated. The individual was hospitalized at the time the prescriber was contacted. The medications were never administered together. • 7/1/13: Clinical intervention for a severe DDI between fenofibrate and pravastatin. The recommendation was accepted. • 8/16/13: Clinical intervention for a severe DDI between new order of Pravachol, fenofibrate, and Omega 3. The recommendation was rejected and no changes were made. • 8/26/13: Clinician intervention for a new lithium order to check lithium level in one week. The recommendation was rejected. The pharmacy director did not present data on the number of recommendations accepted by the prescribers. However, a review of the data showed that a significant number of prospective recommendations were not accepted by the prescribers. While the medical provider has the freedom to deviate from clinical guidelines, the Settlement Agreement requires documentation of an explanation in the record when the pharmacist makes an actual recommendation and the clinician chooses not to accept. The monitoring team was concerned by the substantial number of recommendations rejected because many were related to the failure to follow established protocols and guidelines. Many recommendations related to the prevention of drug-drug interactions were rejected. These drug interactions were clearly outlined in the written drug monographs. The pharmacists documented "telephone" notification of the interactions. During previous reviews, the monitoring team was concerned about the management of notification of drug interactions and recommended that severe drug interactions require direct communication with the prescriber and written information be provided in the form of the drug monographs. The clinical intervention forms did not document that the monographs were provided to the prescribers. Medication and monitoring issues impacted the clinical outcomes of individuals in a number of ways. The facility had long struggled with proper monitoring of individuals who received clozapine. The clozapine policy was recently revised, but there was an abundance of evidence that it was not followed as required. QDRRs noted missing lab	

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		values. The pharmacy director acknowledged that this was problematic. Similar issues were noted with lithium monitoring. Several examples of adverse drug reactions and toxic levels were noted during the conduct of this review: • Individual #393 had a lithium level of 1.29. On 11/21/13, the PCP wrote an order to "Please notify psychiatry of elevated lithium of 1.29." This individual did not have monitoring consistent with protocol. It could not be determined if the PCP directly notified the psychiatrist of the lithium level. • Individual #875 had a sub-therapeutic lithium level. An order was written by the PCP on 9/25/13 to notify psychiatry of the low level. • Individual #367 had multiple changes in lithium doses. Labs were not obtained per protocol, which resulted in increased follow-up, and additional medication changes. One concern with the IA protocols provided to the monitoring team was the language used. Labs were to be obtained within a certain timeframe, which provided significant and undesirable flexibility. For example, lithium levels were to be obtained "within one week. " An order written as such allowed the nursing staff to obtain a level one to two days after the medication was started, which would not be appropriate. The protocols should have specified the number of days, such as obtain a lithium level in 5 to 7 days after dose change. The monitoring team encountered examples in which lithium levels were obtained two to three days after starting the medication or changing the dose. This was addressed with the pharmacy director during the week of the compliance review. During previous reviews, it appeared that greater emphasis was being placed on addressing these issues. The minutes of the Medical Review Committee meetings of the past documented monthly discussions related to prospective medication orders. Documentation for this review was limited to the MRC minutes dated 5/5/13 and 8/14/13. Furthermore, the facility submitted the review of physician orders only for the months of March 2013 and May 2013. This summary data was historically included in the document request. There was some additional information found in the P&T Committee meeting minutes. This was limited to a summary of the total number of interventions that occurred each month. The P&T Committee meeting was conducted quarterly. Per the facility pharmacy services policy, "the review of physician orders and clinical interventions would be discussed monthly with the medical team." While it was reported that discussions were ongoing, and there was evidence of discussions and initiatives prior to the June 2013 review, there was no documentary evidence that many of these problems were being adequately addressed with the medical staff.	

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		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 drugs, including carbamazepine, dilantin, valproic acid, phenobarbital, lithium, levothyroxine, warfarin, and potassium. During the June 2013 compliance review, the monitoring team was informed that statins, acetaminophen, and digoxin were monitored, however, they were not included on the "Monitoring Parameters" listing provided to the monitoring team. The guidelines issued by state office required monitoring for digoxin. MSSLC continued to struggle with the execution of the Intelligent Alerts. 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." There were several concerns related to the IA report submitted to the monitoring team. It was obvious that the report lacked items related to important drug monitoring for drugs, such as lithium, phenobarbital, dilantin, and potassium chloride. This was brought to the attention of the pharmacy director, who upon further investigation, determined that the missing information was related to syntax errors. In addition to this, the report lacked justifications for many entries. The original report was corrected to address the syntax errors, but the corrected report included 19 pages of entries that lacked justifications associated with the entries. This was significantly more blank entries than was seen in the original report. The fact that the facility staff failed to detect the missing entries related to drugs, such as lithium, potassium, dilantin, and phenobarbital in the IA reports was indicative of a lack of an appropriate review of this information. The pharmacy director reported routinely submitting this information to the medical director. However, the medical director appeared to be unaware of the problem related to the lack of justifications in the original reports as well as the missing information related to the syntax errors.	

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		While the facility was documenting communication between pharmacists and prescribers, there were a number of problems, including the management of: • Physician responses to recommendations and documentation of responses • Management of drug interactions, particularly severe interactions • Overall implementation and execution of the Intelligent Alerts <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The pharmacy department should continue to document the interactions between the pharmacists and prescribers. 2. Data should be maintained on the types of interventions and order reviews. The pharmacy director should review the data with the medical director on a regular basis. The medical director should have ongoing discussions with the medical staff based on analysis of the data. 3. The facility must clearly define the management of drug interactions; severe drug interactions should require direct contact with the provider. The drug monographs should be provided to ensure that the prescribers are fully aware of the serious nature of the interactions. 4. As required by the Settlement Agreement, there must be documentation by the provider when the prescriber elects not to follow the recommendation of the pharmacists. 5. The medical director must address the issues identified related to appropriate laboratory monitoring. 6. The issues identified related to the execution of the Intelligent Alerts module must be addressed.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	Quarterly Drug Regimen Reviews were required to be completed every 90 days. Per state office guidelines, " The QDRR may be conducted up to seven days prior to the end of the review period and will be considered delinquent if completed 14 calendar days from the end date of the review period." Setting guidelines to limit early completion was reasonable and prevented the use of a wide margin that could allow serial completion of QDRRs within a few days or weeks to satisfy the requirement of quarterly/within 90-day completion. During the June 2013 compliance review, MSSLC had experienced staffing changes and subsequently experienced a marked decline in compliance with timely completion of the QDRRs. While this had improved significantly, some of the gains were offset by early completion of QDRRs.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A total of 40 Quarterly Drug Regimen Reviews was 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. Much of the information was included in the worksheets completed by the pharmacists. 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. The comments section appeared to be just a series of bulleted items which often did not appear to be clinically related. For example, information such as weight, BMI, and lipids were often presented separately, but were rarely linked together for individuals who received new generation antipsychotic medications to discuss risk of metabolic syndrome. Overall, the clinical content of the QDRRs was adequate. The following represent examples in which the QDRRs noted deficiencies with clinical monitoring or in some cases the monitoring team noted problems with the content of the QDRR: • Individual #505, 6/26/13 o The was no current EKG even though an order was written on 4/12/13. o Seizure records for January 2013 – April 2013 were noted to be incomplete. • Individual #365, 6/21/13 o The last VPA level was noted to be 11/19/12. Levels should have been done every 6 months. • Individual #227, 8/30/13 o The last DISCUS was April 2013. • Individual #475, 8/1/13 o There was no EKG in the active record even though the medication posed a risk of prolonged QT prolongation. • Individual #483, 8/14/13	

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		o The response to inappropriate medication indications was "individual is seen at Scott and White." • Individual #918, 8/23/13 o The clinical pharmacist commented on the risk of metabolic syndrome. However, this individual was clearly diagnosed with diabetes mellitus and received two medications for management. This was also a very young individual (17 years old) who the pharmacist documented had type 1 diabetic retinopathy. This should be investigated if not already done. • Individual #415, 9/9/13 o The last eye exam was April 2012. • Individual #892, 9/25/13 o There was no follow-up lithium level since starting on 9/9/13. o The last eye exam was 5/2/12 • Individual #917, 10/23/13 o The clinical pharmacist noted that the individual had multiple risks for metabolic syndrome, but did not elaborate on the specific risks. It was also documented that the HbA1c was not monitored; however, there was no recommendation to do so. In addition to assessing content, the timelines for completion of the evaluations was also reviewed. Quarterly Drug Regimen Reviews were required to be completed every 90 days. Per state office guidelines, "The QDRR may be conducted up to seven days prior to the end of the review period and will be considered delinquent if completed 14 calendar days from the end date of the review period." Limiting the timeframe was reasonable and prevented serial completion of QDRRs within a few days or weeks to satisfy the requirement of quarterly/within 90-day completion. During the June 2013 compliance review, MSSLC experienced a marked decline in the timeliness of completion of the QDRRs. This was attributed to staffing changes. While this had improved significantly, some of the gains were offset by early completion of some QDRRs. Compliance data were presented at the Pharmacy and Therapeutics Committee meetings. A summary of the data documented in the meeting minutes is presented in the table below.	

QDRR Compliance Data 2013			
Month	No. QDRRs Completed	QDRRs Completed On Time*	% Compliance
Jun	134	48	35.8
Jul	126	27	21.4
Aug	84	48	57.1
Sep	94	80	85.1
Oct	72	53	73.6

#	Provision	Assessment of Status	Compliance
		<table><tr><td>Nov</td><td>56</td><td>38</td><td>67.8</td></tr><tr><td>Total</td><td>566</td><td>294</td><td>52</td></tr></table> *Timelines as defined by state issued guidelines above Overall, there was improvement in meeting the requirements issued by state office. However, the compliance fluctuated each month, resulting in an average compliance for the six-month reporting period of 52%. This was based on the data submitted by the facility for the number of QDRRs completed within the <u>correct</u> timeframe. The pharmacy director reported higher compliance rates which were based on the QDRRs that were completed early. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The clinical pharmacists should address the types of clinical issues noted above. 2. Efforts to complete the evaluations within the required timeframes should be increased. 3. The pharmacy staff should work with the medical director to clarify the requirements for discussing monitoring for metabolic syndrome.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the	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 clinical pharmacist noted polypharmacy for management of conditions, such as seizure disorder and constipation, in addition to psychotropic medications. This was an improvement from the comments observed during the last compliance review. Psychotropic polypharmacy and the Polypharmacy Oversight Committee are addressed in further detail in section J. <u>Anticholinergic Monitoring</u> Each of the QDRRs commented on the anticholinergic burden associated with drug use. The risk associated with each drug was stratified as low, medium, or high. Comments	Noncompliance

#	Provision	Assessment of Status	Compliance
	use of new generation antipsychotic medications.	were made on the presence of management plans. In the case of constipation, many QDRRs now included the findings of the MOSES and DISCUS evaluations, and the use of prn interventions. This was an overall improvement. Monitoring Metabolic and Endocrine Risk The facility monitored individuals for the metabolic risks through the QDRRs. The QDRR worksheet included a table that listed criteria for diagnosis of the metabolic syndrome, including waist circumference, triglycerides, HDL, blood pressure, and fasting glucose. The clinical pharmacists listed individual parameters under the comments section of the report, but rarely linked the various criteria by making a statement related to the overall risk for metabolic syndrome. Additionally, the concept of monitoring for metabolic syndrome presented some challenges once the individual was determined to have a diagnosis of diabetes mellitus. Individuals with a diagnosis of diabetes continued to have discussions related to assessment of risk of metabolic syndrome. The metabolic syndrome can be defined as the co-occurrence of metabolic risk factors for both type 2 diabetes and cardiovascular disease. Metabolic syndrome is an important risk factor for subsequent development of type 2 diabetes and/or cardiovascular disease. Thus, once the individual has a diagnosis of type 2 diabetes, the discussion of risk of metabolic syndrome is no longer the primary issue. Metabolic syndrome increases the risk for diabetes and heart disease and can be considered a condition that precedes diabetes. It was apparent that the actual significance of metabolic syndrome was not well understood based on the comments found in the QDRRs. Compliance Rating and Recommendations The monitoring team disagrees with the facility's self-rating of substantial compliance. In order to move to towards substantial compliance, there must be evidence that the monitoring for the metabolic and endocrine risk occurs in accordance with facility guidelines. There must be documentation of adequate clinical justification if that does not occur. The monitoring team also recommends that educational activities related to risk assessment particularly related to the metabolic syndrome be provided to staff.	
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	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Substantial compliance for this provision item should be determined based on the providers' responses to both prospective and retrospective reviews. This has been clearly stated in previous reviews, yet the self –assessment continued to assess only the responses to the QDRRs.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	individual's medical record a clinical justification why the recommendation is not followed.	Prospective Recommendations Prospective recommendations were generated at the time new orders were written. As discussed in section N1, prescribers frequently rejected the recommendations of the pharmacists. Prescribers are not obligated to accept the recommendations of the pharmacists, but are required to "consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed." The pharmacists documented that there was justification. This appeared to be verbal justification via phone. This occurred even when prescribers elected to ignore severe drug interaction warnings. Retrospective Recommendations The clinical pharmacists also made formal recommendations when completing the QDRRs. Many of the QDRRs indicated that the prescribers accepted the recommendations of the pharmacists. Explanations were provided on the QDRR report when the recommendation was not accepted. The monitoring team was not provided QDRRs for all of the primary care providers who maintained caseloads. Thirty QDRRs were submitted for three providers and the medical director. Forty percent of the QDRRs submitted were reviewed by the medical director while each of the other three providers reviewed 20 percent of the sample submitted. There were two additional primary providers who had been employed at the facility several months prior to the compliance review. No QDRRs were submitted for those two providers. It should be noted that for Round 8 of the external medical audits, the facility did not achieve an acceptable score for the non-essential element that addressed this issue (Question #29). Compliance Rating and Recommendations This provision will remain in substantial compliance. In order for the facility to maintain substantial compliance with this provision item, there must be evidence that the medical staff continue to accept and implement the recommendations of the clinical pharmacists. The medical staff should clearly note in the IPN a clinically justifiable explanation when recommendations are not accepted. There should be evidence that deficiencies related to the medical staff's responses are addressed by the medical director and appropriate corrective actions are implemented. The requirements for this provision are applicable to all medical providers.	
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.	Noncompliance

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		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. The facility had fully implemented the use of AVATAR for completion of the MOSES and DISCUS evaluations. Thus, all evaluations were recorded electronically. Hard copies of the assessments were not maintained. The completion of both assessments was a cooperative effort between the nursing and medical departments. The final component of the MOSES evaluation is the prescriber review, which includes comments related to the determination of side effects and a conclusion. The DISCUS evaluation requires the prescriber document a conclusion. A sample of the most recent MOSES and DISCUS evaluations submitted by the facility, were reviewed. The findings are summarized below: Thirty MOSES evaluations were reviewed for timeliness and completion: • 29 of 30 (96%) were signed and dated by the prescriber • 7 of 30 (23%) documented no action necessary • 4 of 30 (13%) lacked prescriber reviews • 19 of 30 (63%) included comments, but no specific prescriber conclusion Twenty nine DISCUS evaluations were reviewed for timelines and completion: • 26 of 29 (89%) were signed and dated by the prescriber • 23 of 29 (79%) indicated no TD • 1 of 29 (3%) indicated the presence of TD • 4 of 29 (14%) included other comments, other than the presence or absence of TD • 1 of 29 (3%) was blank The most recent evaluations included in the active records of the record sample listed in section L were also reviewed. The findings are summarized below: Ten MOSES evaluations were reviewed for timeliness and completion: • 5 of 10 (50%) were signed and dated by the prescriber • 4 of 10 (40%) documented no action necessary • 2 of 10 (20%) lacked prescriber reviews • 4 of 10 (40%) included comments, but no specific prescriber conclusion Six DISCUS evaluations were reviewed for timelines and completion: • 5 of 6 (83%) were signed and dated by the prescriber • 5 of 6 (83%) indicated no TD	

#	Provision	Assessment of Status	Compliance
		• 1 of 6 (16%) was blank The results reported reflected the full implementation of documentation of the evaluations via the AVATAR program, which had the ability to document the conclusion. The reports submitted to the monitoring team, as well as those found in the active record, did not include the prescriber reviews observed during demonstrations and seen in computer screen shots. Therefore, prescribers were required to hand write information required for the prescriber review. This requirement was not consistently executed. In some instances, no information was documented. In other instances, there were comments, but the comments were not always related to the prescriber review. Determining the timeliness of completion was also difficult due to multiple date entries, such as assessment, data entry, report printing, and signature dates. There was usually a significant delay between the date of the nursing assessment and the date of the physician's signature. Many of the evaluations lacked a nursing signature and date. Overall, the multiple dates, the lack of a standardized format for prescriber comments, the lack of format for signature/dates, and the absence of a prescriber review resulted in incomplete evaluations. The monitoring team must emphasize the importance of conducting timely and thorough monitoring for the occurrence of medication side effects particularly in individuals with developmental disabilities who may be unable to verbally communicate the presence of problems. While 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. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the facility must take several actions: 1. The MOSES and DISCUS forms must be executed as designed. The facility will need to address issues related to implementation of AVATAR and the need to have the prescribers fully <u>complete and document the evaluations</u>. 2. The evaluations must be completed in a timely manner. 3. The evaluations must be fully completed. 4. The information must be utilized in clinical decision-making. *5.* The data <u>must be reviewed by the primary providers</u> in addition to being reviewed by the psychiatrists and neurologists.	

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<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 continued to report ADRs. Training was provided in New Employee Orientation and 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="7">Adverse Drug Reactions Reported 2013</td></tr>
<tr><td></td><td>Jun</td><td>July</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td></tr>
<tr><td>Number of ADRs</td><td>5</td><td>2</td><td>14</td><td>8</td><td>3</td><td>3</td></tr>
<tr><td>% Reported by Medical Staff</td><td>60</td><td>50</td><td>64</td><td>50</td><td>33</td><td>33</td></tr>
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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 as tremors and extrapyramidal symptoms. Notwithstanding the increase of reporting by the medical staff, the monitoring team had several concerns about the ADR reporting and monitoring system. For example, Individual #57, was hospitalized due to a suspected ADR related to Clozaril. The ADR summary data documented “Found on floor unresponsive…. Started on Dilantin, but was seen, but Dr. Cowen who recommends Keppra. He did not specify if seizure was due to Clozaril, but did say he believed he was having a period of seizure.” Although this individual was hospitalized due to a possible ADR, there was no further review of the case as it related to an adverse drug reaction.

A hospitalization associated with a suspected ADR warranted further review. Per facility policy, “For reported ADRs that are classified as severe and required hospitalization, an intense case analysis will be performed.” The policy continued to require that such ADRs be reported to the FDA and ADRs with an RPN number of 24 or greater require further review. The number assigned to this case was 20 and, therefore, no review was conducted.

The June 2013 compliance report highlighted that a caveat of using a failure mode effect analysis system is that such systems are proactive evaluations while intense ADR reviews are generally retrospectively completed with the intent of identifying issues related to systems and person specific care. The RPN threshold was not crossed, however, the clinical pharmacist noted that the neurologist “did not specify if the seizure was related to Clozaril.” If the seizures were new onset, it would have been prudent to conduct a further review relative to the causal associations. The monitoring team suggests that the clinical pharmacist review alternative severity scales, such as a modified Hartwig scale.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		In addition to the aforementioned ADR, documentation also revealed that there were several ADRs related to EKG changes, such as bradycardia and prolonged QT intervals. It appeared that follow-up was not always prompt. For example, Individual #540 initially had EKG changes reported in December 2012 related to the use of Mellaril and Risperdal. Documentation in the MRC minutes of 10/16/13 indicated the mother wanted the medications to continue in spite of continued concerns regarding QT prolongation. The psychiatrist was to speak with the mother. Subsequent documentation indicated that the individual completed cardiology evaluation. The IPN documentation of Individual #160 indicated that the PCP had diagnosed the individual with valproic aid toxicity on 10/23/13. Lab studies showed an increasing VPA level. The individual experienced nausea vomiting and other symptoms. There was no documentation of VPA toxicity as an ADR. Throughout the conduct of this review, there were numerous accounts of deficiencies related to properly obtaining EKGs as required for medication monitoring. QDRRs frequently noted that EKGs were not in the active records or were overdue, sometimes significantly overdue. Yet the monitoring team could not determine that any initiatives were undertaken to improve compliance with this important requirement even though it appeared to be a recurrent problem and the monitoring was clearly necessary based on the ADRs being reported. It is important that (1) facility staff comply with the monitoring guidelines such as obtaining EKGs, (2) abnormalities are recognized, (3) data related to abnormalities are analyzed, and (4) corrective actions are taken based on the results of data analysis. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The reporting efforts should continue. 2. 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. 3. There should be continuous monitoring of individual and aggregate data. 4. The pharmacy director will need to review the process for the ICA. The goal is to conduct a through review of cases that meet a pre-determined threshold of the circumstances and systems surrounding the event using appropriate methodology. 5. The facility should consider the use of alternative severity thresholds. There are many options, including the use of the scales similar to the Hartwig severity threshold.	

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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>6. 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.</td><td></td></tr>
<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. A DUE on Lithium was completed and presented at the September 2013 Pharmacy and Therapeutics Committee meeting.

A DUE on the use of bisphosphonates was presented at the P&T Committee meeting held during the week of the compliance review. The presentation included information related to the objective, methodology, and results of the evaluation and recommendations. The monitoring team noted that the facility chose three process and three outcome indications. Process indicators included bone density examinations, diagnosis of dysphagia, use of appropriate medication administration instructions. Outcome indicators included bone density scores, appropriate diagnosis, and appropriate medication dose. The process for selection of indicators should be reviewed as neither diagnosis nor medication dose would appear to be true reflections of outcomes.

The Pharmacy and Therapeutics Committee Minutes continued to document some discussion of the DUEs as well as follow-up of issues identified by the evaluations. With Pharmacy and Therapeutics Committee meetings conducted on a quarterly basis, it is imperative that there is documentation of corrective action plans inclusive of the timelines for the necessary action steps.

<u>Compliance Rating and Recommendations</u>
The monitoring team agrees with the facility's self-rating of substantial compliance. Consideration should be giving to including the work done relative to reporting FDA alerts in the either the DUE policy or the general pharmacy services policy. The pharmacy director should address the comments above related to indicator selection.</td><td>Substantial Compliance</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 some progress was observed in this area. The medication data provided to the monitoring team are summarized in the tables below.

<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td></tr>
<tr><td>Total</td><td>98</td><td>98</td><td>157</td><td>134</td><td>131</td><td>114</td><td>99</td><td>108</td><td>78</td><td>88</td><td>122</td><td>83</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. During this meeting, it was observed that there was a problem with the categorization of medication variances. There was no real oversight of the process. Each discipline head made a</td><td>Noncompliance</td></tr>
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		decision on the level of variance, there was no review by the committee, and there was no sample of inter-reliability checks completed. Thus, the monitoring team questioned the accuracy of the data reported. Another problem was the obvious lack of participation by all clinical disciplines. Per state policy, each discipline was responsible for management of errors inclusive of development of corrective action plans. A review of the meeting minutes showed no compelling evidence that the medial department was meeting this requirement. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The appropriate parties should review every step in the medication use system at MSSLC ensuring that best practices are in place and agency and state policy is being followed. That is, the facility should continue to work on all aspect of the medication use system. When problems are identified, the appropriate corrective actions should be implemented. 2. The current process of assigning the category of variance should be reviewed. The facility needs a system of oversight to ensure that variances are being assigned the correct level. All clinical disciplines with documented medication variances should maintain the appropriate documentation of the variances, the corrective action plans that address the variances and the follow-up to closure.	

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 o Habilitation Therapy Services Policy 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 and P QA Reports o PNMT Evaluation template o PNMT Meeting documentation submitted o CMD Committee meeting minutes o Infection Control meeting minutes o Morning Medical Meeting minutes o List of individuals on PNMT caseload o List of individuals referred to the PNMT in the last 12 months o List of Individuals Discharged from the PNMT in the last six months o ISPA attendance log o PNM spreadsheets o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Completed Compliance/Effectiveness 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 Annual Refresher curriculum materials related to PNM o Documentation of staff training submitted 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 Documentation related to choking event for Individual #318 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 APEN Evaluations for Individual #197, Individual #257, Individual #518, Individual #512, Individual #220, Individual #38, Individual #314, Individual #293, Individual #61, and Individual #175. o PNMT Assessments and ISPs submitted for Individual #216. o PNMPs and ISPAs for the following individuals (Sample 0.2): Individual #38, Individual #395, Individual #597, Individual #518, Individual #285, and Individual #154. o Information from the Active Record including: ISPs, all ISPAs, pre-ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #427, Individual #216, Individual #266, Individual #80, Individual #503, Individual #220, Individual #376, Individual #43, Individual #407, Individual #588, Individual #310, and Individual #293. o PNMP section in Individual Notebooks for the following: • Individual #427, Individual #216, Individual #266, Individual #80, Individual #503, Individual #220, Individual #376, Individual #43, Individual #407, Individual #588, Individual #310, and Individual #293. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last

	12 months for the following: • Individual #427, Individual #216, Individual #266, Individual #80, Individual #503, Individual #220, Individual #376, Individual #43, Individual #407, Individual #588, Individual #310, and Individual #293. <u>Interviews and Meetings Held</u>: o Christian Sykes, RN o Jennifer Capers, RD, LD o Teresa Koppang, MS, CCC/SLP o Lisa Phillips, RD, LD o Karen Sweet, OTR o Sandra Opersteny, PT Interim Habilitation Therapies Director o Lisa Finley, COTA o Dr. McClary o Various supervisors and direct support staff o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas o ISPA Meeting for Individual #47
	Facility Self-Assessment: The self-assessment continued to be thorough, though did not always relate to the elements reviewed by the monitoring team. Findings were reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. Despite this, the facility requested reduced monitoring of six of the eight elements of section O, that is, all but O.3 and O.8. The monitoring team encouraged them to also consider review of O.1 to which the Interim Director, Sandra Opersteny, PT agreed. Reduced monitoring was accomplished by summarizing activities reported and reviewing the status with a small sample only. The self-assessment proposed that MSSLC was in substantial compliance with O.3 and O.8. The monitoring team concurred for O.3, but not O.8 as described below. The monitoring team also found substantial compliance with O.1. Though progress had been made, all other areas were self-rated in noncompliance by the facility and the monitoring team agreed. The action plans laid out by the previous

	director will be significantly helpful in directing the current and/or future leadership to move forward in a positive and coordinated direction.
	Summary of Monitor's Assessment: As in previous reviews, it was evident that a tremendous amount of work had been done in this area. Substantial compliance was achieved in provisions O1 and O3. There was a fully constituted PNMT. Although all current members were not the same as during the previous visit, meeting attendance and participation had been maintained at a consistent level. They implemented recommendations related to streamlining their documentation, tracking the established measurable outcomes in the minutes while keeping the meetings organized and on point. Observations during this onsite visit revealed that very clear improvement had been made in each of these areas. It is critical that the IDTs initiate timely referral for individuals who meet the established criteria. Referral to the PNMT is not to suggest that the IDTs are not doing their job well, but is rather a reflection of the complexity of the individual's needs and the urgency for intervention. During the meeting observed, the team demonstrated excellent discussion and problem solving. Their assessments and other documentation, clearly and concisely reflected this process. The Mealtime Coordinators were in place and appeared to understand their role, though it was unclear how they were trained. Despite this new support, there continued to be errors in implementation of Dining Plans across a number of homes. Approximately 50% of staff were able to answer questions about the supports they provided. Others required significant prompts before they could answer correctly. In general, there continued to be issues related to ensuring there were sufficient staff to provide the necessary supports for individuals who needed prompts throughout the meal related to bite size and pace of eating. Re-positioning was also a concern. Positioning continued to improve, but there was an ongoing need to reposition individuals throughout the day and to check the position of individuals after mechanical lift transfers. The transfer does not end when the individual is placed in the seat. Techniques used for re-positioning continued to be problematic. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 12 individuals, 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 six individuals who were assessed or reviewed by the PNMT over the last six

	months, not included in Sample O.1. Sample O.3 consisted of individuals at MSSLC who received enteral nutrition. Some of these individuals might also have been included in one of the other two samples.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility 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	MSSLC used the state-issued PNM policy (#012.3, effective 3/4/13), though had not formally operationalized it. • The facility did not have a single comprehensive PNM policy that addressed the scope of PNM issues outlined below, but rather, through a combination of facility policies, guidelines and procedural documents, generally outlined a complete and comprehensive system of Physical Nutritional Management. Though each of the following elements were not specifically outlined in those documents, these were clearly in practice at the time of this onsite review: o Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); o The annual review process of an individual's PNMP as part of the individual's ISP; o The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; o The roles and responsibilities of the PNMT; o The composition of the facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; o Description of the role and responsibilities of the PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); o The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; o Requirements for continuing education for PNMT members; o Referral process and entrance criteria for the PNMT; o Discharge criteria from the PNMT; o Assessment process; o Process for developing and implementing PNMT recommendations with Integrated Health Care Plans;	Substantial Compliance

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	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.	o The PNMT consultation process with the IDT; o Method for establishing triggers/thresholds; o Evaluation process for individuals who are enterally fed; o PNMT follow-up; o Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; o A comprehensive PNM monitoring process designed to address all areas of the PNMP, including: ▪ Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, ▪ Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide), ▪ Identification of monitors and their roles and responsibilities, ▪ Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, ▪ Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician, and ▪ Frequency of monitoring to be provided to all levels of risk. o A system of effectiveness monitoring; and o Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. <u>Core PNMT Membership</u>: 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 duties, with the exception of the nurse, which was a full time position. Team members included the following with start dates: • Christian Sykes, RN (December 2012) • Jennifer Capers, RD, LD (July 2013, though had previously served on this team) • Teresa Koppang, MS, CCC/SLP (June 2013) • Lisa Phillips, RD, LD (October 2013) • Heather Helton, OTR (January 2013) • Karen Sweet, OTR (December 2013) • Sandra Opersteny, PT (June 1991)	

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		As in previous reviews, a number of the team members were new to this team since the previous review, with the exception of the PT and RN. Jennifer Capers had previously been the dietitian for the team and had temporarily resumed this responsibility to replace the dietitian in place during the previous review. She attended the meeting observed by the monitoring team during the onsite review in order to provide training and support to the newly assigned dietitian, Lisa Philips. Specific back-ups for each position had not been assigned, but rather the assigned IDT therapists for individuals reviewed by the PNMT were to attend and participate in the absence of any core team member. There had been limited consistency of core team members since the baseline review. <u>Consultation with Medical Providers and IDT Members</u> A large number of medical providers including nurses, physicians, dentists, respiratory therapists, and pharmacists were listed as medical consultants, though none was listed as primary. There were 26 meetings held between 6/5/13 and 12/5/13. Physicians (Dr. Ellis and/or Dr. McClary) attended or participated by telephone in PNMT meetings as follows: • 14 of 26 meetings (54%) for the six month period, during which the percentage increased to 74% for the second half of the six month period, and 86% for the last two months. Moreover, in addition to actual attendance at PNMT meetings, effective medical consultation, support, and involvement was consistently provided in other ways. The PNMT RN or designee also attended daily clinical medical morning meetings, pneumonia committee meetings, quarterly infection control meetings (Opersteny, Phillips, and Capers), and others in which the physicians also participated consistently. Further a Choking, Modified Barium Swallow Study, and Dysphagia Committee (CMD) had been established and members of the PNMT and physicians attended these meetings, as well as others. Daily Medical Provider Meeting minutes were submitted for 11/1/13 through 12/3/13. Others were submitted, but attendance sheets were not. Attendance by the PNMT representative was clearly recorded for 26 of 28 meetings (93%). The reports from these meetings were discussed by the PNMT in order to update the status of individuals on their caseload, to track others with PNM concerns, and to identify individuals who met criterion for referral to the team. The PNMT RN also served as the liaison between the PNMT and the physicians by personally meeting with them to discuss pertinent issues and to ask questions, as indicated. All PNMT assessments were reviewed and signed by a physician. • For 0 of 28 PNMT meetings (0%) held from 6/5/13 to 12/5/13, there was evidence of participation by IDT members, however, as described above, IDT	

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		therapists attended some meetings in the absence of a core team member. o PNMT consistently reviewed their findings with the IDT upon completion of the assessment and routinely attended IDT meetings related to individuals they reviewed or who were referred to the PNMT. o PNMT members attended 108 of 116 (93%) of the ISPA meetings related to individuals seen by PNMT. o This provided significant alternate opportunities for collaboration in assessment, planning, implementation of interventions and actions, follow-up, and monitoring. <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 per license identification cards submitted. • 5 of 5 core PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Collectively, the team members had approximately 62 years (including Jennifer Capers) of experience in their respective fields and, with the exception of the new dietitian, each had more than three years experience with individuals with intellectual disabilities and/or physical nutritional management related concerns. • 5 of 5 PNMT staff (100%) had completed continuing education directly related to physical and nutritional supports and transferable to the population served within the past six months. At least two of these individuals were no longer employed at MSSLC and one was no longer a core team member. Lisa Phillips was not listed with any continuing education, but she was new to the team at the time of this review. Back-up team members were also listed with related continuing education in the last year. A number of relevant courses were attended by team members: • Jessica Barry, MS, CCC-SLP (3 contact hours in the last year) • Christian Sykes, RN (3 contact hours in the last year) • Sandra Opersteny, PT (96 contact hours in the last year) • Heather Helton, OTR (18 contact hours in the last year) • Jennifer Capers, RD, LD (8 hours in the last year) • Barbara Jones, RD, LD (7.5 hours in the last year) Ongoing continuing education related to PNM and transferrable to the population served is essential to ensuring that an adequate level of expertise is maintained for all team	

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		members, individually and collectively, via cross training. <u>PNMT Meetings</u> • Since 6/5/13, all PNMT meeting minutes (100%) included (a) referrals, (b) review of individual health status, (c) PNMT actions, and (d) follow-up. Since July 2013, goals and exit criteria were clearly stated and updates related to (e) outcomes/progress toward established goals and exit criteria were clearly outlined on a consistent basis. Meeting minutes were submitted for 6/5/13 to 12/5/13 (a total of 28 meetings). A list of attendees was included in the meeting minutes. • Since the last onsite review, the team met at least weekly basis for 27 of 28 weeks (96%), missing only the week of the Thanksgiving holiday. Based on review of the minutes, attendance by core PNMT members and/or back-ups for the meetings conducted during this time frame was: • RN: 25/27 (93%) by core member, 0/27 (0%) by back-up, and 93% overall. • PT: 20/27 (74%) by core member, 4/27 (15%) by back-up, and 89% overall. • OT: 23/27 (85%) by core member, 2/27 (7%) for back-up, 93% overall. • SLP: 24/27 (89%) by core member, 2/27 (7%) for back-up, 96% overall • RD: 19/27 (70%) by core member and assigned replacements, 0/27 (0%) for back-up, 70% overall Attendance was generally above the criterion of 80% for core team and well above the 90% criterion overall, with the exception of the RD, related to turnover. There had been much improved consistency in RD attendance with the assignment of Jennifer Capers and the hiring of Lisa Phillips. It was expected that with stabilization of this position consistent attendance would be maintained. It was expected that with turnover of any core team member, a back-up would be consistently assigned to attend the meetings until such time that the vacant position was filled. The meeting minutes were maintained in a table format and included the following elements: • Member attendance • Individual reviewed (referrals and active caseload) • Discussion • Action Step • Person Responsible • Date due • Date done	

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		• Reason for referral • PNMT goals • Discharge criteria Date of next review, weight, and weight range were not consistently documented. Per previous recommendations by the monitoring team, the PNMT meeting minutes consistently identified the status of goals and discharge criteria with each review. An episode tracker was maintained with review of individuals who presented with a change of status and/or presented with health concerns that may trigger a need for referral. A follow-up tracker also permitted the team to review referral information and dates of follow-up to permit ready reference to specific meeting minutes • The facility PNMT had a sustainable system fully implemented for resolution of systemic issues and concerns. This was integrated into the policies in place and evidenced in the monthly QA reports. There was a system of corrective action plans in the case that system issues were identified. They addressed the following: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT are collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting): ▪ A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan): ▪ Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and ▪ If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. Examples of identified system issues addressed included an extensive policy related to the choking event process and the Choking, Modified Barium Swallow, and Dysphagia Committee (CMD). Section O requires that the PNMP be reviewed at the individual's annual individual support plan meeting, and as often as necessary, approved by the IDT, and included as	

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		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 PNMT. These aspects, though outlined in O.1 of the Settlement Agreement, are actually reviewed in O.3 below. The monitoring team determined that the facility was in substantial compliance with this element of section O. It was expected that the attendance by the core team RD would continue to be consistent with the established criteria of 80%, and 90% with back-up. Also, as discussed with the Interim Director, steps should be taken to carefully outline all procedural guidelines to further operationalize the current state policy related to PNM and the PNMT currently implemented.	
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.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Identification of PNM risk</u> All individuals at MSSLC identified with PNM needs (203 per the list submitted) 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. • Some of the individuals with PNMPs were reported to be fully independent, but only had shoe inserts, some of which were not even customized, yet a PNMP was provided. This required an annual assessment and at least quarterly review. The monitoring team encouraged Habilitation Therapies to consider if this need could not be more effectively addressed via the ISP process rather than the provision of a PNMP and assessment. • There were approximately another 124 individuals identified with no PNM needs. These lists were maintained and updated as required. Based on lists of individuals with identified PNM concerns, there were individuals who (a) Required physical assistance for positioning associated with swallowing: 38 individuals, (b) Were dependent on others to eat: 123 individuals, (c) Had difficulty swallowing: 90 individuals, and/or (d) Were considered to be at medium or high risk of choking (approximately 92 individuals) or aspiration (approximately 87 individuals). • Of those identified in any of these categories (collectively, "individuals having physical or nutritional management problems"), 100% were listed with a PNMP.	Noncompliance

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		There were three incidents of choking documented in the last year (Individual #300, Individual #431, and Individual #276). Each of these events resulted in staff performing abdominal thrusts (Heimlich). Follow-up documentation was submitted for Individual #431 only. In that case, assessment by the SLP occurred at the time of the next meal. The Dining Plan was modified to state that staff must sit at the table with Individual #431. There was reference to removal of bacon from his diet because this was the item he choked on. • This was an unacceptable solution. The food item should be modified if indicated, or proper supervision should be provided, rather than restricting the individual's diet, whenever possible. This appeared to be an over-reaction to this event and should be reviewed. • While the response to this event was completed in a timely manner, there was no evidence of SLP assessment in follow-up to the other two choking episodes. Each was listed with a PNMP. Individual #431 and Individual #300 were appropriately assigned a risk of choking, but Individual #276 was not. These designations should be reviewed. Individual #231 was listed with a choking incident on 10/19/13, per the emergency room visit log, though there was no evidence of follow-up submitted. There were no subsequent choking episodes for these or any other individuals reported. Improvements were noted in the completion of the risk rating tools, as evidenced by the ISP observed during this onsite review and based on review of the IRRFs. The plans to address specific health risk issues were included in the IRRFs and IHCPs consistent with current state policy and practice. <u>PNMT Referral Process</u> Per the State Physical Nutritional Management policy #012.3 (3/4/13), individuals identified by the IDT who were at high risk as defined by the At Risk policy (#006) and for whom the IDT was not able to achieve a satisfactory outcome or remediate the risk level, may be referred to the PNMT by the PCP, PNMT, or IDT for assessment and recommendations for interventions and supports. More specific criteria guidelines were outlined, though individual circumstances and risk levels would dictate more or less stringent criteria: • Two choking episodes 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: o Aspiration Pneumonia; o GI Issues o Fractures;	

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		o Skin Integrity; and o Seizures • New or proposed enteral feeding; • Unresolved vomiting (more than 3 in 30 days, not related to viral infection); • Significant/unplanned/verified weight loss or gain of o More than 5 pounds in one month; o 3 or more pounds per month for three consecutive months or 7.5% of body weight per month for 3 consecutive months; or o 10% of body weight in 6 months; • Any Stage III or IV decubitus, or any Stage II with delayed healing; or • Fracture of a long bone, spine, or hip There were no established timelines within which to review and determine a need for PNMT involvement. Training had been provided to IDTs in the past. There were nine individuals listed on the current active caseload for the PNMT (Individual #503, Individual #216, Individual #266, Individual #888, Individual #314, Individual #43, Individual #597, Individual #441, and Individual #310). It could not be determined from the list submitted how many of these were self-referred versus those referred by their IDT, though five of these had been referred since the previous review. Individual #441, Individual #888, and Individual #43 were not listed as referred, but included as on the active caseload. A PNMT episode log was maintained. It tracked the incidence of health issues that may have required referral to the PNMT. Ideally this should be recognized by the IDT in a timely manner. Otherwise, the PNMT identified these concerns and solicited a referral at that time. This system appeared to be effective in most cases. While this system was very thorough, there appeared to be some individuals who likely should have received a PNMT evaluation and did not. For example, it was noted that three individuals had gastrostomy or gastrostomy/jejunostomy tube placement in the last year, however, following the onsite review the facility reported that two of the individuals on the list submitted to the monitoring team had their tubes replaced, that is, these were not new tubes (Individual #285 and Individual #314). Individual #216 was referred on 8/8/13, with tube placement on 9/13/13. Individual #188 and Individual #293 had multiple discharge diagnoses of aspiration pneumonia, though no evidence of referral was noted. Individual #266 experienced a spiral fracture of the ulna (July 2013), Individual #539 experienced a proximal humeral shaft fracture (October 2013), and there was no evidence of referrals for these individuals at the time of those events. Further determination could not be	

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		identified based on the documentation submitted. For example, dates of incidents for pneumonia, fractures (also location of fracture), among others were not provided. Requests for presentation of this information had occurred in previous reviews. It was noted, however, that in most cases, for issues documented in the assessments, the referrals had been made, regardless of source. It could not be determined in all cases that this was within five days of an event or if the threshold met warranting referral. There were two individuals who had received enteral tube placements since the previous review (Individual #285 and Individual #216). • 1 of 2 individuals who received a feeding tube since the last review (50%) had been referred to the PNMT prior to the placement of the tube. The following metric was not applied as the circumstances of tube placement could not be determined based on the documents submitted: • __ of __ individuals who received an emergency feeding tube placement (%) since the last review had been referred to the PNMT after the emergency feeding tube placement. Incidence of conditions in various PNM-related risk areas were tracked by the team and reviewed by the PNMT the Episode Tracker for easy reference. Consideration of at least the following issues for tracking was consistently indicated: • Weight loss/gain • Fractures (long bones, pelvis, spine) • Skin Breakdown • Pneumonia • Recurrent aspiration • Respiratory compromise • Constipation • Bowel Obstruction • Fecal impaction • Recurrent bowel related concerns • GI issues • Dehydration • MBSS • Choking • New or Possible Enteral Tube Placement • Feeding tube clogged • Poor oral hygiene • Urinary tract infection	

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		• Hospitalizations/Change in Health Status • Other <u>PNMT Assessment</u> 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. Assessments submitted included the following: • Individual #38 (4/16/13) • Individual #518 (5/9/13) • Individual #314 (5/10/13) • Individual #98 (5/13/13) • Individual #1 (6/5/13) • Individual #493 (6/5/13) • Individual #597 (8/12/13) • Individual #503 (9/17/13) • Individual #266 (9/19/13) • Individual #310 (10/14/13) • Individual #216 (9/6/13) Of these, seven assessments were completed and had been dated during the last six months. Due to the abbreviated review, only the most current assessment (Individual #216) was analyzed below: • The PNMT assessment was initiated at a minimum within five working days of the referral, per the dates identified in those assessments. • The PNMT assessment was completed in 30 days or less of the date of referral, per the date in the assessment heading. Actual completion date could not be determined because there were no dated signatures. Based on review of this assessment, the following elements were included: • Date of referral by the IDT (or self-referral). Referral source was not identified. • Date the assessment was initiated. The first date of assessment was presumed to be the date it was initiated. • Evidence of review and analysis of the individual's medical history. • Identification of the individual's current risk rating(s), including the current rationale. • Recommended risk ratings based on the PNMT's assessment and analysis of relevant data. • Assessment of current physical status. • Assessment of musculoskeletal status. This was conducted in a limited manner	

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		by the nurse only. • Evaluation of skin integrity. The nurse reported that she was not able to access anterior/posterior perianal area at the time of her evaluation. In that case, that should be assessed at another time, particularly because that is an area prone to skin breakdown and she was considered to be at medium risk for skin integrity concerns. It was stated that this was not relevant to the reason for referral, so was not addressed. • List of medications with potential side effects listed. This did not include drug/drug or drug/nutrient interactions and/or actual side effects. A review of a nutrition assessment completed six months earlier addressed some of these, but the list of medications in that assessment was not consistent with the list at the time of the current PNMT evaluation. • Identified residual thresholds, if enterally nourished (not applicable in this case). • Tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation. • Information about the individual's current respiratory status based on a physical assessment. • Evidence of observation of the individual's supports at their home and/or day/work programs. • Evidence that the PNMT conducted hands-on assessment. • Identified the potential causes of the individual's physical and nutritional management problems. • Identified physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rational for the recommendations. • Recommendations for measurable skill acquisition programs, as appropriate. This did not appear to be indicated at the time of the assessment for Individual #216. • Evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP). • Recommendations for monitoring, tracking or follow-up by the PNMT. • Discussion as to whether existing supports were effective or appropriate. • Signatures of all core team members (or alternate). The following elements were not addressed sufficiently: • Discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition. • Dates of signature by core team members (or alternates). • Measurable outcomes related to baseline clinical indicators, including, but not limited to when nursing staff should contact the PNMT. The outcomes were	

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		identified, but there were no specific indicators for when nursing staff should contact the PNMT. • Establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. • Evidence of review/analysis of medication history over the last year and current medications, such as dosages, administration times, and side effects. • Evidence of review/analysis of lab work. • Nutritional assessment, including, but not limited to, history of weight and height, intake, nutritional needs, and mealtime/feeding schedule. • Evaluation of current assistive equipment. Though listed, there was not a clear and current assessment of effectiveness. The OT/PT assessment sited had been completed five months earlier. • Evaluation of posture and alignment in bed, wheelchair, or alternate positioning, or indicated that the individual was independent with mobility and repositioning. Only a head of bed elevation (HOBE) assessment was conducted at the time of the PNMT evaluation. The previous OT/PT assessment had been completed five months earlier. • Positioning that may impact PNM status including during bathing and oral hygiene based on observations of these activities; • Evaluation of motor skills. Objective clinical indicators should be established for individuals followed by the PNMT as part of the assessment's recommendations because they may serve as clues for potential change in status. For example, key clinical indicators should be identified that alert the IDT that the individual may need an increase in intervention or monitoring and may be as basic as vital signs or meal refusals. In the case of Individual #216, one of the objectives was "no episodes aspiration pneumonia for three months requiring hospitalization." While this may be an appropriate discharge criterion, there would likely be other clinical indicators noted before reaching that level. • These should be integrated into the IHCPs. • These will not likely be the same objectives for discharge from the PNMT. The IHCPs and PNMPs for individuals with physical or nutritional management difficulties require effectiveness monitoring of individual-specific objective clinical data to determine the efficacy of the interventions (of which PNMT interventions are a part). PNMT review would be necessary to determine if the plan was being implemented as written, if staff were adequately trained, etc. If the team determined that 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.	

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		Integration of PNMT Recommendations into IHCPs and/or ISPs/ISPAs • All recommendations by the PNMT were addressed/integrated in the ISP/ISPA, IRRFs, and IHCPs for Individual #216. An ISPA was conducted upon completion of the assessment to develop the Change of Status IHCP and all PNMT recommendations were integrated into that plan. PNMT members were consistently present at that meeting. Plans resulting from PNMT recommendations included the following components: • Identified PNM needs as presented in the PNMT assessment were addressed. Per the documentation submitted, the tube placement for Individual #216 occurred on 9/13/13, yet the revised PNMP dated 8/30/13 identified that she was NPO (nothing by mouth). Per IPNs at that time, she continued to eat orally, however. There was no evidence of review of the PNMP after tube placement until 10/11/13, nearly one month later. • The HOBE recommendations were not clearly integrated into the plan. The specifics related to the HOBE were not addressed in the IHCP, but rather only referred to the PNMP. • Functional and measurable objectives were outlined to allow the PNMT to measure the individual's progress and efficacy of the IHCP and PNMP. • There were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • The specific clinical indicators of health status to be monitored were included. • Frequency of monitoring was included. PNMT Follow-up and Problem Resolution Each of the recommendations identified in the PNMT assessment should be clearly and consistently tracked through to completion. This appeared to be the case for Individual #216. The format of documentation was improved and made it easier to track original recommendations and those required as a function of ongoing review. Intervals of PNMT review were clearly stated, and these appeared to occur on a timely basis. A system that addressed implementation of recommendations and other actions should be developed to permit the PNMT (meeting minutes) and others to readily review this information (IPNs). The IPNs were consistently entered by the PNMT, but did not always accurately reflect actions taken, outcomes, and dates of completion. Guidelines for these should be developed. For example, there was an IPN related to completion of a HOBE on 10/18/13 for Individual #216. The note referred the reader to a consult for specifics, but this was	

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		not contained in the individual record. The details should be addressed in the IPN rather than a separate document. <u>Individuals Discharged from the PNMT</u> Discharge was noted for Individual #216. There was no evidence of the following: • ISPA meeting to discuss the discharge of the individual from the PNMT to the IDT. • Discharge summary to provide objective clinical data to justify the discharge and to identify any new or outstanding recommendations for integration into the IHCP. • Evidence of ISPA documentation and/or action plan that included clinical indicators to track health status and criteria for referral back to the PNMT, particularly if they differed from the criteria included in the PNMT policy. In some cases, for an individual already reviewed by the PNMT, multiple events such as choking or aspiration, related to the original reason for referral should be addressed before the first reoccurrence whenever possible. This ensures that the concerns are addressed in a proactive, rather than reactive manner. As stated in previous reports, an effective PNM program requires that the referral to the PNMT occur in a timely manner, so as to capitalize on the collective expertise of the team members. There is 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. At this time, the MSSLC PNMT appeared to understand this responsibility. The team is commended for its hard work, expertise, and follow-up, though continued efforts related to the content and thoroughness of the documentation of their work is indicated as outlined above. The facility self-rated this provision in noncompliance and the monitoring team concurred. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure that actions taken are adequately documented in the IPNs. 2. 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 and documented. 3. Ensure that the PNMT assessments address the essential elements outlined above.	

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		4. Refine the process of re-referral to be based on clinical indicators rather than only event-based PNM issues.	
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.	MSSLC requested full review of this element of section O due to reported progress made over the last six months. <u>Identification of Individuals Requiring a PNMP</u> As described above, at least 99% of individuals who required a PNMP were provided one. The Settlement Agreement (in O.1, but reviewed here) 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 ISP meeting. Teams are also required to provide clear justification if they decide that therapists involved in the individual's care and treatment do not need to attend. For individuals in Samples O.1, ISP attendance and pre-ISP documentation related to required attendance were reviewed. Regarding attendance: • 11 of 12 individuals' annual ISPs (92%) noted that appropriate disciplines were present to approve and integrate the PNMP into the ISP. A clinician from Habilitation Therapies was present at 11 of 12 meetings (92%). o It is the opinion of the monitoring team that, due to extensive cross-training, co-assessments, and collaboration in the development of the MSSLC PNMP across OT, PT, and SLP, Habilitation Therapies clinician attendance was a reasonable approach to ensuring that there was adequate coverage for PNMP review. • In one case, there was no designation for any Habilitation Therapy attendance (and perhaps as a result, none were in attendance), but there should have been, based on PNM needs (Individual #220). The facility had recently implemented a pre-ISP meeting whereby, three months prior to the ISP, the IDT met to plan for the ISP meeting, including designating who should attend the meeting. For 8 of these 12 individuals (67%), the disciplines noted during the pre-ISP meeting attended the ISP meeting. This was a relatively new process and it was expected that improvements in consistency would be noted over the next six months. For this review, as noted immediately above, the monitoring team determined that appropriate habilitation therapy attendance occurred at 11 of the 12 meetings. The facility, however, should ensure that those identified during the pre-ISP meeting do attend the meeting.	Substantial Compliance

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		Regarding PNMP review: • 12 of 12 PNMPs (100%) were reviewed by the individual's IDT in the annual ISP meeting. The reviews documented in the ISPs were thorough and specific, and were related to changes required and efficacy. This was good evidence that the process used (collaboration across disciplines related to assessment and PNMP development, as well as Habilitation Therapy representation) was effective to ensure adequate and appropriate review during the ISP meeting. • For 8 of 9 (89%) individuals in Sample 0.1 for whom the IDT identified changes needed to be made to the PNMP, revisions based on the IDT discussion were documented in an ISPA, including rationale, and plan and timeline for implementation. The discussions were clear and consistently documented for review of changes in status, such as hospitalizations or other changes in health status and there was evidence that the IDT reviewed the PNMP at that time to determine the need to modify these plans. The ISPA stated that no changes were required or generally delineated what changes were required. Though a clear time for completion was not stated, the changes were made, in most cases, that day or within 48 hours. The exception was related to Individual #310. A suction toothbrush was added to his PNMP as of 10/31/13, though this was not clearly outlined in an ISPA at that time. An ISPA dated, 10/21/13, indicated that there was an order for suction toothbrushing, though this was not implemented until at least 10 days later. There were also earlier references in a number of ISPAs related to both regular toothbrushing and suction toothbrushing, thus, it was not at all clear which was in place and when. There was an IPN related to the addition of suction tooth brushing as early as 9/24/13 written by the PNMT. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample 0.1: • PNMPs for 18 of 18 individuals (100%) were current within the last 12 months. This was consistent with the previous review. • PNMPs for 18 of 18 individuals (100%) included a list of PNM risk levels and individual triggers. This was consistent with the previous review. • In 18 of 18 PNMPs (100%), there were large and clear photographs with instructions. Though some copies were submitted were black and white, the originals were prepared in color. This was an improvement from 33% in the previous review. • 18 of 18 PNMPs (100%) identified the assistive equipment required by the individual, though rationale or purpose was not consistently identified for every piece of equipment for some individuals who had multiple items. This was consistent with the previous review.	

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		• In 15 of 15 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions were provided. • In 18 of 18 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 18 of 18 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. This was consistent with the previous review. • In 18 of 18 PNMPs (100%), bathing instructions were provided. This was consistent with the previous review. • In 18 of 18 (100%) PNMPs, toileting-related instructions were provided, including check and change. This was an improvement from 93% in the previous review. • In 18 of 18 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. Each of the others was described as independent. This was an improvement from 0% in the previous review. • In 18 of 18 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was consistent with the previous review. • 18 of 18 individuals' (100%) Dining Plans were current within the last 12 months. This was consistent with the previous review. • 8 of 18 individuals had feeding tubes with no oral intake and one other who ate orally. 8 of 8 PNMPs/dining plans (100%) specifically stated that the individual was to receive nothing by mouth, when indicated. This was an improvement from 80% in the previous review. • In 18 of 18 PNMPs (100%) and 12 of 12 dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. This was with an improvement from 50% in the previous review. • 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 10 of 10 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. This was an improvement from 90% in the previous review. • In 10 of the 10 PNMPs/dining plans for individuals who ate orally (100%), 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.	

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		This was an improvement from 40% in the previous review. • In 18 of 18 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 18 of 18 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. This was consistent with the previous review. • 18 of 18 PNMPs (100%) included information related to communication (how individual communicated and how staff should communicate with individual). This was an improvement from 33% in the previous review. The PNMPs reviewed were generally very good, with comprehensive content and improvement noted in all areas. <u>Change in Status Update for PNMPs Conducted by the IDT/PNMT</u> • For 12 of 15, or 80% (Sample O.1 and O.2), individuals' ISPA meeting documentation noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. As stated above, the discussions were clear and consistently documented review of changes in status, such as hospitalizations or other changes in health status and there was evidence that the IDT reviewed the PNMP at that time to determine the need to modify these plans. The ISPA stated that no changes were required, or it delineated what changes were required. o Exceptions were three instances of suction toothbrushing being added to the PNMP without documentation in an ISPA. Because these instances were limited to the initiation of suction toothbrushing and because the many other changes to the PNMPs for these three individuals were documented in ISPAs, the monitoring team allowed the rating of substantial compliance for this provision. ▪ Individual #395, Individual #310, and Individual #154 related to the addition of suction toothbrushing. In the case of Individual #395, the use of a suction toothbrush was added to his PNMP on 5/23/13, though this was not clearly identified per the ISPA on that date. The RN had completed the assessment as of the ISPA on 5/15/13, but action identified was to follow-up only at that time. No further determination was noted in the ISPA. In the case of Individual #154, suction toothbrushing was also added to her PNMP on 5/23/13, but there was no evidence of that in the ISPAs submitted. A suction toothbrush was also added to Individual #310's PNMP as of 10/31/13, though this was not	

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		clearly outlined in an ISPA at that time. As described above, documentation was inconsistent related to his use of suction toothbrushing. • For individuals for whom the PNMP was revised, there was supporting documentation that 14 of 15 (93%) individuals' revised PNMPs had been implemented. The changes were included in the PNMT meeting minutes, ISPAs (with the exceptions identified above), PNMPs, and IPNs. Training logs reflected staff training when indicated. The changes were made, in most cases, that day or within 48 hours. Other non-critical changes were made in less than 30 days (i.e. adding braces for Individual #395, 20 days after ISPA). This was not unreasonable to allow time to order, fit, and provide staff training. An exception pertained to Individual #395, however, in that the IDT decision to discontinue his braces on 7/11/13 was not reflected in the PNMP until 9/5/13. The monitoring team concurred with the facility that they were in substantial compliance with this provision. To maintain substantial compliance: 1. Documentation of required changes to the PNMP should be clearly and consistently evident in the ISPAs. 2. Documentation of changes to the PNMP should also be more consistently documented in the IPNs to alert all team members that changes were made. 3. Full implementation and review of the pre-ISP process is necessary to ensure that the appropriate IDT members are present for continued review of the PNMP. 4. Continue with the existing audit process as this, as well as the training, clearly affected positive changes in the content of the PNMPs.	
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.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Monitoring Team's Observation of Staff Implementation of PNMPs</u> Dining Plans were generally readily available in the dining areas (with few exceptions) and PNMPs were included in the individual notebook (though these were not immediately available in some homes). General practice guidelines (foundational training) were taught in NEO and in individual-specific training by the therapists and PNMPCs. Based on observations conducted by the monitoring team, it was noted that: • 25 of 40+ individuals' (63%) dining plans were implemented as written. • 31 of 40+ individuals' (78%) PNMPs related to positioning and mobility were implemented as written, or alignment and support were consistent with generally accepted standards.	Noncompliance

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		Based on additional observations: • 1 of 3 (33%) individuals' transfer plans/repositioning were implemented appropriately or consistent with generally accepted standards. While the transfer steps were completed safely in most cases, the staff did not consistently attend to the individual's position after placement in the wheelchair, particularly when using a mechanical lift. Re-positioning is often necessary after placement to ensure that the individual is aligned properly. Techniques used to accomplish this were not routinely consistent with generally accepted standards (Individual #503, for example). • (NA) individuals' bathing plans were implemented appropriately or consistent with generally accepted standards. No bathing was observed during this review, so this metric was not rated. Some additional comments: • Concerns noted related to implementation of PNMPs/Dining Plans were: o presentation techniques o mealtime position o pace of presentation o re-positioning techniques o bed positioning (Individual #503) o bite size o use of verbal and physical prompts. • Findings reported by MSSLC from monitoring conducted, was inconsistent with the observations by the monitoring team • In some cases, the dining areas were not adequately sanitized between individuals. Five of 10 (50%) staff were able to answer questions related to risks and the purpose of strategies outlined in the PNMP or Dining Plan. Staff should not routinely need to refer to the plans to answer these types of questions. Review of the plans and risks should be done when the staff are initially assigned for the day, and reviewed prior to implementation. Staff should have an active knowledge of the individuals to whom they are assigned on any given day: • Staff are 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	

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		triggers or clinical indicators so that any necessary action may be taken promptly. • Staff should review plans just prior to implementation of strategies, particularly at mealtime and, as such, information should be fresh on their minds. The facility had implemented Mealtime Coordinator (MTC) training consistent with the statewide plan, though the process used was not known to the Habilitation Therapy staff. A Mealtime Coordinator was seen in each of the homes. Though training materials were submitted, the process used to train-the trainers, to provide training to MTCs and to establish their competency was not clear to the monitoring team. The Mealtime Coordinators were asked about this and some stated they had attended training and others stated that a supervisor had explained their responsibilities. Standardization of this process is essential to ensure adequate competency of these key staff. Unit directors were involved in the implementation and oversight of the program. The monitoring team concurred with the facility's self-rating that they were not in compliance with this provision. The rate of errors observed continued to be too high. The revised training materials related to implementation of the PNMP for direct support staff was excellent and should contribute to further improvements in implementation. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Fully implement the Mealtime Coordinator system. Review the process for training these key staff to ensure consistency and to document competency. 2. Ensure there is further focus on transfer and re-positioning techniques to improve staff performance in these areas. 3. The current system used to monitor staff compliance was not adequate. This system must be revised and implemented.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. <u>NEO Orientation</u> Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. Class time was very limited (a total of approximately 10.5 hours) to address the PNMP, lifting and transfers, and dining plans and eating skills. The Lifting and Transfers portion of the curriculum was taught by licensed therapy staff, assisted by PNMPCs and PT technicians, and check-offs of participants were conducted in class. Communication was addressed in a two hour time period and is addressed in section R below.	Noncompliance

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		The content, based on review of the curriculum materials, was comprehensive. The PNM-related core competencies (i.e., foundational skills) included in the NEO training appeared to be comprehensive. There were a number of associated knowledge and skills-based competency check-offs for most of this content. • It was of concern though as to how quickly this content had to presented, allowing limited time for practice and check-offs for new employees. Employees were expected to pass all essential elements of the identified core competencies. The new employee was required to demonstrate competency of foundational skills by safely performing each step, for each foundational skill, without coaching from the evaluator. Upon completion of classroom hours, the new employees participated in a mealtime practicum conducted by CTD. The Habilitation Therapies department did not know what this specifically entailed, however. There was a system to establish competency for staff who provided the training, including the therapy clinicians, PNMPCs, and CTD staff. It did not appear that a system to ensure continued competency was in place, however. • Approximately 100% of new employees successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. Staff were retested until they passed skill tests by report. <u>PNM Core Competencies for Current Staff</u> • 100% of current staff that required training successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. All staff attended annual refresher training, though this was limited to lifting and transfers only. Staff were required to pass CBT skill check offs within two attempts with a combined score of 80%. If unable to do so, they had to retake the course. • 100% of staff responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. <u>Individual-Specific Training</u> The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. All staff had demonstrated competence in the core foundational skills through NEO and refresher training. Non-foundational training was completed for all staff in each home for the individuals who lived in that home. All staff were trained related to the PNMP prior to the	

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		provision of services. It was not clear, however, that all staff had completed competency check-offs in all specialized components of PNMPs (i.e., non-foundational skills) for high–risk individuals prior to the provision of services. All PNMPCs responsible for training other staff successfully completed competency-based training for foundational competencies (core) and the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. The facility had a process to validate that staff responsible for training other staff were competent to assess other staff's competency. The monitoring team concurred that the facility was not in compliance with this provision. There were a number of implementation/compliance errors related to mealtimes and positioning. It appeared, however, that significant improvement had been accomplished in each of these areas. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Continue to focus on staff performance through training, coaching, and monitoring. 2. Reinforce the role and responsibilities of the Mealtime Coordinators as well as supervisory staff in identifying and correcting staff performance errors. 3. Consider expanding existing training and implement annual refresher training for mealtimes and communication. 4. Refine the system of validating trainers to establish competency as well as to maintain this. This should be clearly outlined in procedural guidelines.	
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.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Facility's System for Monitoring of Staff Competency with PNMPs</u> The monitoring tool used was a universal form that did not provide adequately discrete measures of staff competence. The elements of that form were very general and it made it difficult to identify more discrete issues for tracking and analysis. This form had been replaced in a number of other SSLCs for that reason. In addition, this same form was used for effectiveness monitoring conducted by the therapy clinicians. This form did not provide adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. For example, based on the current form, the materials or equipment	Noncompliance

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		could be absent, not in working order, and/or utilized correctly and compliance would be rated at 90%, or in compliance. Further, the plan itself could also be missing and compliance would be rated at 80%, that is, in compliance. This was a significant flaw in the process. The check-off form used by CTD in NEO training, had more discrete measures to establish some aspects of competency during mealtime assistance than the form used by Habilitation Therapies. The universal monitoring tool included adequate instructions. The staff conducting monitoring were competent in the areas they were monitoring (therapy clinicians only). The monitoring frequency was quarterly for all individuals with a PNMP. This did not, however, ensure that all elements of these plans were monitored for staff compliance or for effectiveness, conducted concurrently by licensed therapists. No other compliance monitoring was conducted at the time of this review, though nursing did complete some mealtime monitoring. These findings were not integrated into other findings from Habilitation Therapies, however. Some of the forms outlined the specific activity observed, but others did not mark this aspect of the form. As such, it was not possible for the facility to fully analyze the scope of monitoring conducted across all aspects of PNM. The monitoring team routinely requested compliance monitoring forms that were completed for individuals included in Sample 0.1 for the last three months. Due to the request for reduced monitoring, these were not analyzed as was typically done for this review. It was noted, however, that the PNM monitoring process did not adequately balance all areas that were likely to provoke swallowing difficulties, or increase other PNM risk, based on: • Meals • Bed positioning • Wheelchair positioning • Medication administration • Oral care • Bathing • Transfers • Other elements as indicated, including special assistive equipment such as gait belts, walkers, braces, splints, etc. This is a very critical aspect of PNMP implementation and again skewed the perception of compliance. As described above, there were issues related to staff performance of	

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		transfers, re-positioning, and mealtime assistance. Overall, observations by the monitoring team did not result in similar findings with regard to PNMP and dining plan implementation as compared with the compliance data the facility's monitors reported (greater than 90% compliance). Below are comments regarding this process and how it may skew the facility's self-assessment of staff compliance and/or plan effectiveness: • The PNMP in the individual book was not the most current, yet the monitor marked this as in compliance. • One individual was described as not wearing the prescribed orthopedic shoes due to blisters, yet the PNMP was marked as 100% effective. • An individual was described with increased head/neck flexion in her wheelchair, yet the effectiveness of the plan was marked as 100% effective. • Seat cushion was described as torn. There was no indicator that permitted the monitor to identify this on the form, but was rather reported in the IPN only. The monitoring was deemed 100% compliant and 100% effective. • The monitor marked "N/A" for the indicator "Staff communicates with individual before and during activities." Communication with the individual should always be an applicable indicator. • In some cases, only a transfer was monitored. In other cases, only a piece of equipment. In each of these, the entire PNMP was deemed to be effective. • There was no mechanism to ensure that all aspects of the plan were monitored on a routine basis. The monitoring team concurred with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Identify and correct issues related to the monitoring process to include the following: o Monitoring related to all aspects of the PNMP (transfers, tooth brushing, bathing, and medication administration, specifically) o Consider a method to calculate the percentage of compliance on the form. o Review the frequent use of "N/A", particularly for key aspects of the PNM monitoring process. The repeated use of this designation significantly skews the results and does not provide an adequate picture of staff performance across all elements of PNM. 2. Consider use of a more discreet monitoring tool to address the concerns identified above. 3. Consider modification of the existing system of monitoring, to ensure more comprehensive and frequent monitoring for individuals, particularly for those at	

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		greatest risk.	
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.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Effectiveness Monitoring</u> There was also a system established for routine evidence of effectiveness monitoring by the therapists. As described in O.6 above, this process was paired with compliance monitoring and completed by licensed therapists. Each time this was completed, the clinician wrote an IPN identifying the effectiveness of the plan or its elements. As described above, there were some weaknesses in this process. In addition, there was no review of the individual's health status related to the supports and services provided. For example, in the case that an individual had specialized bed positioning to address aspiration, it may likely be determined that it was not fully effective if the individual experienced aspiration pneumonia. There was no means to address this with the current process. Effectiveness monitoring should include intervention and program implementation across all environments and not only in the home. This was not consistent as most were conducted in the home only. Staff compliance monitoring should occur across all time periods that the plan may be implemented and not only during the usual business hours of the clinician. The Habilitation Therapy department may want to consider using tracking logs that include supports and services provided. The therapists could use the PNMT Event Log to identify concerns for the period of review as well as chart review to summarize the individual's health status. The effectiveness monitoring spreadsheet should track findings and the timeliness of the monitoring. The monitoring team concurred with MSSLC's finding for noncompliance with this provision. It was a concern that not all PNM strategies and interventions 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. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish clear guidelines for completion of this monitoring. Audits and further training may be indicated to improve consistency. 2. Address effectiveness monitoring across all aspects of the plans or other indirect supports and services. These should occur across all environments and not only	Noncompliance

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		in the home. 3. Ensure the tracking system tracks timeliness of effectiveness monitoring as recommended, in addition to the findings.	
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.	MSSLC requested full review of this element of section O due to reported progress made over the last six months. <u>Evaluation of Individuals who Received Enteral Nutrition</u> The facility maintained and updated a list of individuals who were enterally fed (though by report, two individuals who were listed with tubes first placed in 2013, were actually tube replacements, Individual #314 and Individual #285). There was a list of individuals that identified 26 individuals who received enteral nutrition (8% of the current census). Four individuals were listed with gastrostomy-jejunostomy tubes, while the others had gastrostomy tubes. Seventeen received intermittent feedings, seven received continuous, and two received bolus feedings. Twenty-two were identified as NPO and the other four received some level of oral intake (pleasure feeding). • 7 of 10 individuals (70%) who received enteral nutrition (Sample O. 3) were evaluated at a minimum annually based on the APENs submitted. Three APENs were not dated, so this could not be determined for (Individual #293, Individual #38, and Individual #197) • 6 of 10 individuals with APENs submitted (60%) had an appropriate evaluation to determine the medical necessity of the tube since the previous review. APENs lacked an adequate assessment by the dietitian regarding current formula and schedule of feedings (Individual #293). Most did not appear to present a determination if the feeding schedule was the least restrictive or if there were potential modifications needed in preparation of transition to oral intake. Also, there was not sufficient oral motor review to address potential for any level of oral intake or interventions that may be indicated (Individual #61, Individual #512, and Individual #518). • For 6 of 10 individuals, there was evidence of adequate discussion by the team related to the medical necessity of the team. This was not evident for Individual #61, Individual #512, and Individual #518. • __ of the __ individuals who received enteral nourishment and were admitted since the last review (NA) had a review of the medical necessity of the feeding tube within 30 days. <u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> • All individuals who received enteral nutrition (Sample O.3) were evaluated by the IDT to determine if a plan to return to oral intake was appropriate. It was noted,	Noncompliance

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		however, that most did not clearly reflect assessment by the SLP and/or OT regarding oral motor status and as to whether the individual was a candidate for an oral motor treatment program (to improve potential for intake by mouth or for improved saliva control). Justification for/or against oral motor treatment or potential PO intake should be included as a part of assessment findings. • __ of the __ individuals (NA) who were identified as potentially benefitting from oral motor treatment, or 0 of 1 cleared to return to some form of oral intake (0%), had a comprehensive plan outlining the treatment or return to PO process. The times for trial meals were outlined, but there were no measurable outcomes outlined or clinical indicators to identify progress or success related to oral intake, other than she would be supplemented with enteral intake if oral intake was less than 50% to 75% at a trial meal. No other parameters were identified or ruled out as necessary. • 0 of the 1 individuals' (0%) plans to return to oral eating were based on the results of the IDT's discussion and were integrated in the IHCP, ISP, and/or an ISPA. • __ of the __ individuals' (NA) plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. The IHCP was not submitted for Individual #61. • __ of __ staff responsible (NA) for implementation of these oral intake plans were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. It could not be determined. The APEN stated only Habilitation Therapy staff would provide trial meals, but it could not be determined if this was licensed clinicians only or other staff who would require competency-based training. • __ of the __ individuals' plans (NA) were monitored as outlined in the plan. 0 of 0 individuals' plans were modified by the IDT. There was no plan for this. • For __ of __ these individuals' (NA) plans, the IDT met and interventions were reviewed and changed, as appropriate, in a timely manner. There was no evidence of this. 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.	

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		PNMPs 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. The monitoring team did not concur with MSSLC's self-rating of substantial compliance with this provision at this time. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish protocol related to the completion of assessments, especially related to nutrition and oral motor evaluation, on an annual basis to determine the medical necessity of all individuals with enteral nutrition. 2. Ensure that discussion related to medical necessity and return to oral intake are clearly documented in the ISP/IRRF and IHCP as appropriate. 3. Establish clear support plans with clinical indicators for individuals with potential to return to oral intake and/or who would benefit from therapeutic intervention to address issues that may be barriers to return to oral intake.	

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 templates 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 Documentation 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 PNM/Assistive Equipment Maintenance Log o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions o OT/PT Assessment Tracking Log o Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to MSSLC: Individual #795 and 944 o OT/PT Assessments, ISPs, and ISPAs for the following individuals: • Individual #175, Individual #795, Individual #109, Individual #300, Individual #123, Individual #47, Individual #63, Individual #321, Individual #549, Individual #532, Individual #464, Individual #25, Individual #595, Individual #297, Individual #401, Individual #504, Individual #589, Individual #800, and Individual #1 o OT/PT Assessments, ISPs, and ISPAs, and other documentation related to OT/PT intervention for the following individuals: • Individual #816, Individual #795, Individual #574, Individual #154, and Individual #588. o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #427, Individual #216, Individual #266, Individual #80, Individual #503, Individual #220, Individual #376, Individual #43, Individual #407, Individual #588, Individual #310, and Individual #293. o PNMP section in Individual Notebooks for the following: • Individual #427, Individual #216, Individual #266, Individual #80, Individual #503, Individual #220, Individual #376, Individual #43, Individual #407, Individual #588, Individual #310, and Individual #293. o Dining Plans for last 12 months, Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #427, Individual #216, Individual #266, Individual #80, Individual #503, Individual #220, Individual #376, Individual #43, Individual #407, Individual #588, Individual #310, and Individual #293. <u>Interviews and Meetings Held</u>: o Sandra Opersteny, PT Interim Habilitation Therapies Director o Lisa Finley, COTA

	o OTs, PTs, Hab technicians and PNMPCs o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas o ISP Meeting for Individual #160
	Facility Self-Assessment: The self-assessment continued to be thorough, though it did not always relate to the elements reviewed by the monitoring team. Findings were reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. Despite this, the facility requested reduced monitoring of all elements of Section P. This was accomplished by summarizing activities reported and reviewing the status with a small sample only. While onsite, however, the monitoring team determined that a full review for P1 would be appropriate because it seemed possible that it was in substantial compliance. Though progress had been made, all areas were found to be in noncompliance by the monitoring team, ratings that were the same as made by the facility in its self-assessment.
	Summary of Monitor's Assessment: There was continued, but limited progress toward substantial compliance in all aspects of provision P. Efforts to improve the content of assessments were noted. Though there were some improvements in assessment content, on-time completion of assessments continued to be problematic. There had been improvements noted in previous months, by report, there had been a more recent decline in timeliness over the last month before this onsite review. There was improvement in the quality of OT/PT assessments for this review period. • There were improvements in 10 (45%) of the elements. • There was regression in three of the elements (14%). • Four others were consistent with the previous review; two at 100% and two others at 0%. • The average for all 10 assessments was approximately 68%. o 0 of 14 assessments (0%) contained 100% of the 22 elements listed above.

	o 2 of 14 assessments (14%) contained 80% or more of the elements listed above. o 3 of 14 assessments (21%) contained 70% or more of the elements listed above. o All other assessments (71%) contained below 70% of the elements listed above. There were few intervention plans and SAPs in place for individuals with OT/PT needs and those reviewed were not well documented with an assessment and discharge summaries. There was an audit system in place that did not appear to be effective in addressing the compliance of essential elements. Another primary concern, however, was the timeliness of assessments, which was calculated at 61% were dated as completed at least 10 working days prior to the annual ISP (based on the sample reviewed). This was an improvement from 8% in the previous review. There were 117 assessments listed in the facility's tracking log for ISPs dated 3/19/13 through 9/19/13. Based on this log, 73% of the assessments were performed on, or prior to, the designated due date. This was an improvement from 12% in the previous review. For ISPs listed since 8/1/13, however, the on-time percentage was actually 100% per this log. This was commendable, but could not be confirmed based on the assessments submitted. <u>Samples for Section P:</u> • Sample P.1a: 12 individuals for whom an individual record and the most current OT/PT/SLP assessment was submitted. • Sample P.1b: assessments submitted by clinicians as most current • Sample P.2: 2 individuals newly admitted in the last six months for whom a current assessment was submitted. • Sample P.3: 5 individuals who were provided direct OT and/or PT services per the list submitted.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed,	MSSLC requested reduced monitoring for this element of provision P. Due to reported improvements in the timeliness and content of OT/PT assessments, the monitoring team encouraged the Interim Director, Sandra Opersteny, PT, to consider full review of this element and she agreed at the time of the onsite visit. This review follows. <u>Assessments</u> The following individuals in Samples P.1a and P.1b had Comprehensive Evaluations current within the last 12 months (dates listed are the signature dates): • Individual #175 (10/14/13) • Individual #795 (8/26/13) • Individual #220 (9/4/13) • Individual #109 (7/29/13) • Individual #300 (9/4/13) • Individual #123 (1/31/13) • Individual #47 (8/30/13)	Noncompliance

#	Provision	Assessment of Status	Compliance
	that shall consider significant medical issues and health risk indicators in a clinically justified manner.	• Individual #63 (9/12/13) • Individual #321 (9/30/13) • Individual #549 (7/23/13) • Individual #532 (8/14/13) • Individual #310 (3/12/13) • Individual #407 (7/16/13) • Individual #266 (4/5/13) • Individual #376 (5/10/13) The Assessment of Current Status was not considered a stand-alone evaluation, but rather served as an addendum or update to the previous Comprehensive Evaluation. Both should be contained in the individual record. The following individuals had Updates/Assessments of Current Status completed within the last 12 months and each had an associated Comprehensive Evaluation submitted and/or contained in his or her individual record: • Individual #464 (8/22/13) • Individual #25 (10/30/13) • Individual #595 (10/17/13) • Individual #297 (8/13/13) • Individual #401 (9/5/13) There were no Comprehensive Evaluations submitted and/or contained in the individual records with the Assessments of Current Status for the following individuals: • Individual #43 (5/6/13) • Individual #80 (1/25/13) • Individual #427 (1/25/13) • Individual #588 (10/21/13) • Individual #293 (8/28/13) • Individual #504 (10/2/13) • Individual #589 (there were no dated signatures on the Assessment of Current Status, so the completion date could not be determined) • Individual #800 (7/10/13) • Individual #1 (incomplete per copy submitted) No OT/PT assessments were contained in the individual records for Individual #216 and Individual #503, though each should have received one (Sample P.1a).	

#	Provision	Assessment of Status	Compliance
		Timeliness of Assessments Twenty-eight individuals were admitted to MSSLC since the last review. A Comprehensive Evaluation was submitted for only two of these (Individual #795 and Individual #944) (five were requested). It would appear that at least five would have been available for submission. Based on this small submission: • 2 of 2 individuals in Sample P.2 (100%) received an OT/PT assessment within 30 days of admission based on the Admission Activity list and the signature dates on the assessment. The following metric was not applied because MSSLC had begun to use an OT/PT screening for individuals newly admitted to the facility since the previous review, screenings were not submitted for review: • If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening (%), received a comprehensive OT/PT assessment within 30 days of identification. There were 28 current OT/PT evaluations submitted for individuals in Samples P.1a (none for Individual #503 or Individual #216) and P.1b. Also, ISPs were submitted for all 12 individuals included in Sample P.1a and 10 in Sample P.1b. Of these, all were current within the last 12 months, though two were incomplete per copy submitted (Individual #300 and Individual #47). Timeliness of the current OT/PT assessments was as follows: • 17 of 28 individuals' OT/PT assessments or updates (61%) were dated as completed at least 10 working days prior to the annual ISP. This was an improvement from 8% in the previous review. • There were 117 assessments listed in the facility's tracking log for ISPs dated 3/19/13 through 9/19/13. Based on this log, 73% of the assessments were performed on, or prior to, the designated due date. This was an improvement from 12% in the previous review. o For ISPs listed since 8/1/13, however, the on-time percentage was actually 100% per this log. • 28 of 28 assessments (100%) were current within 12 months for individuals in Sample P.1a and P.1.b who were provided PNM supports and services. OT/PT Assessment Only current Comprehensive Evaluations included in Sample P.1a and P.1b were included in the following analysis. The assessment identified as comprehensive in the headings for Individual #532 was described as an Assessment of Current Status in the summary on page five and, as such, was not included in the analysis below. The elements listed below are the minimum basic elements necessary for an adequate comprehensive OT/PT assessment. The assessment format and content guidelines generally required that these elements be in the assessments. The analysis for comprehensiveness of the OT/PT/SLP	

#	Provision	Assessment of Status	Compliance
		assessments was as follows: • 13 of 14 assessments (93%) were signed and dated by the clinician upon completion of the written report. This was an improvement from 81% in the previous review. • 14 of 14 assessments (100%) included medical diagnoses. • 14 of 14 assessments (100%) included medical history. • 6 of 14 assessments (43%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. • 11 of 14 assessments (79%) addressed health status over the last year. • 5 of 14 assessments (36%) included comparative analysis that clearly analyzed health status compared with previous years or assessments. • 10 of 14 assessments (71%) included a section that reported health risk levels that were associated with PNM supports. This was an improvement from 13% in the previous review. • 13 of 14 assessments (93%) listed medications and potential side effects relevant to functional status. This was an improvement from 75% in the previous review. • 13 of 14 assessments (93%) included individual preferences, strengths, and needs. This was an improvement from 75% in the previous review. • 9 of 14 assessments (64%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). This was an improvement from 31% in the previous review. • 13 of 14 assessments (93%) 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 an improvement from 38% in the previous review. • Ten individuals in the samples reviewed required a wheelchair. Four of 10 assessments (40%) provided a description of the current seating system with a rationale for each component and need for changes to the system outlined as indicated, also with sufficient rationale. This was a decrease from 67% in the previous review. • 0 of 14 assessments (0%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. This was consistent with the previous review. • 11 of 14 individuals' OT/PT assessments (79%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. This was an improvement from 75% in the previous review. • 14 of 14 assessments (90%) included documentation of the efficacy and/or introduction of new supports in the PNMP that address the individual's PNM risk levels. This is a new metric since the previous review. • 3 of 13 assessments (23%) included discussion of the individual's potential to develop new functional skills. This was an improvement from 8% in the previous	

#	Provision	Assessment of Status	Compliance
		review. • 14 of 14 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct OT/PT interventions and/or skill acquisition programs as indicated for individuals with identified needs. This was an improvement from 63% in the previous review. • 0 of 14 assessments (0%) included a monitoring schedule. This was consistent with the previous review. • 12 of 14 assessments (86%) included a re-assessment schedule. This was a decrease from 100% in the previous review. While all assessments mentioned future assessments, they did not definitely identify when the next evaluation should be done, such as upon referral, at the next annual meeting, or in three years. An individual with identified needs should have an annual assessment or sooner if needed based on a change in status. • 14 of 14 assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This was consistent with the previous review. • 6 of 14 assessments (43%) detailed the supports and services needed for successful community living. This was a decrease from 50% in the previous review. • 14 of 14 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This was consistent with the previous review. The Assessment of Current Status was considered an update to the previous Comprehensive Assessment. In that case, the existing Comprehensive Assessment should be available in the individual record along with each subsequent Assessment of Current Status, until such time that the comprehensive was repeated (i.e., in three years, or other established interval per policy or assessment recommendation). At that time, each would be purged and replaced by the new Comprehensive Assessment and the cycle would be repeated. There were new assessment formats recently developed by the state and distributed. These contained standardized main headings were to be used by all disciplines. The facility was in the process of implementing these changes. There were 14 individuals in Sample P.1a and P.1b with current Updates/Assessments of Current Status, but only five had associated Comprehensive Assessments submitted and/or contained in the individual records (Individual #464, Individual #401, Individual #297, Individual #595, and Individual #25). The following metric should be considered in the implementation of the Assessment of Current Status as it is standardized at MSSLC. • For ___ of __ individuals for whom Updates/Assessments of Current Status were completed, the updates provided the individuals' current status, a description of	

#	Provision	Assessment of Status	Compliance
		the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data from the previous year and monitoring and re-assessment schedules. Further findings revealed continued improvements related to OT/PT assessments as follows: • There were improvements in 10 (45%) of the elements. • There was regression in three of the elements (14%). • Four others were consistent with the previous review; two at 100% and two others at 0%. • The average for all 10 assessments was approximately 68%. o 0 of 14 assessments (0%) contained 100% of the 22 elements listed above. o 2 of 14 assessments (14%) contained 80% or more of the elements listed above. o 3 of 14 assessments (21%) contained 70% or more of the elements listed above. o All other assessments (71%) contained below 70% of the elements listed above. There was overall improvement in the quality of OT/PT assessments for this review period, though this was limited. The average for all evaluations in the sample was only 68% related to inclusion of the essential elements, though was an improvement from 44% in the previous review. There was an audit system in place involving self-assessments. This would be an appropriate approach at such time as all clinicians have demonstrated competency with the elements identified above. There was a reported improvement of on-time assessments submitted since 8/1/13 of at or near 100% submitted on or prior to the due date of 10 days prior to the ISP. To continue to move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure that assessments are completed by the due dates (10 days prior to ISP). 2. Ensure that the audit system promotes improvements in the content of OT/PT assessments at or near 90%. Consider setting benchmarks for the department as a whole as well as for individual therapists in order to achieve this. 3. Clarify the function and format of the Assessment of Current Status. 4. Ensure that completed assessments are filed in the individual records. 5. Consider contacting other facilities who have been found in compliance with this provision to identify additional strategies to ensure continued progress.	

#	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.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Direct OT/PT Interventions:</u> There were 10 individuals listed as participating in direct OT and/or PT and five of these were included for review in Sample P.3 as follows (Individual #816, Individual #795, Individual #574, Individual #154, and Individual #588). • For 2 of 5 individuals (40%), an OT/PT assessment or consult identified the need for OT/PT intervention with rationale. The annual assessment dated 4/4/13 for Individual #816 was incomplete, per the copy submitted, and no other assessment or consult established the need for OT or PT even though he received both of these services. The assessment for Individual #574 was requested on 4/8/13, but the assessment reported that the referral had not been received until 4/15/13 and the consult was conducted the following day. • 0 of 5 individuals had direct intervention plans (0%) implemented within 30 days of creation or sooner as indicated by the individual's health and safety. The first evidence of the implementation of an intervention plan for Individual #574 was not until 4/30/13. He had a knee injury (4/7/13) and the referral was dated 4/8/13. While this was under the 30 day period, intervention should have begun in a timelier manner due to the acute nature of his injury. There was no evidence of an intervention plan for the skilled PT recommended for Individual #588 per his annual assessment dated 10/21/13. • For 0 of 5 individuals (0%), there were objectives related to functional individual outcomes included in the ISP or ISPA. • For 1 of 3 individual's record (33%) whose therapy had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. Therapy (OT and PT) for Individual #816 appeared to continue as of 11/2/13, but there was no documentation submitted related to interventions offered after that time. There was no evidence or rationale for discharge. There was no actual discharge summary written by the clinician, but rather only the statement that she would discuss this with the IDT. The actual status of progress related to the established goals was not clear per the note written on 10/25/13. An ISPA held on 10/30/13 documented the rationale for discharge from OT services, however. The system for documentation was consistent for each of the individuals reviewed. The rationale and plan with measurable and functional objectives was noted in most cases. Most of the documentation submitted was on a SPO treatment plan filed in the Habilitation Therapy tab of the individual record rather than in the IPNs.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Progress notes/IPNs: • 4 of 5 individuals receiving direct OT/PT Services (80%) were provided with comprehensive progress notes (IPNs) at least monthly that contained each of the indicators listed below: o 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); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. <u>Indirect OT/PT Interventions:</u> The primary indirect OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O.3 above regarding PNMP format, content and integration into the ISP and section S for skill acquisition plans. Implementation of PNMPs is addressed in section O.5. <u>Integration of OT/PT Interventions, Supports and Services in the ISP</u> Review of the PNMP and Dining Plans are required by the IDT at least annually during the ISP meeting. This requires that key team members be present, including the OT and/or PT clinicians. The current system required that the IDT designate which team members were required to attend the ISP during the pre-ISP meeting. Pre-ISP meeting documentation was requested for each individual in Sample P.1a, but documentation was not submitted. This designation was marked on a few of the sign-in sheets for the 12 individuals in the sample, but did not appear to be a valid way for the monitoring team to determine which IDT members were required to attend the meeting. Review of the ISPs for Samples P.1a submitted was as follows: • 100% (12 of 12) of the ISPs submitted were current within the last 12 months. • 100% (12 of 12) of the current ISPs had attached signature sheets. • 33% (4 of 12) of the current ISPs with signature pages submitted were attended by both the OT and PT. • 8% (1 of 12) were attended by PT only. • 42% (5 of 12) was attended by OT only. • 17% (2 of 12) of the current ISPs had no representation by an OT or PT, though each had PNM needs.	

#	Provision	Assessment of Status	Compliance
		The facility needs to clearly establish a rationale for attendance by all team members and, once established, attendance should be consistent with this rationale. Clinicians may find the need to negotiate their attendance based on actual services and supports provided and/or proposed to be provided. This element was self-rated to be in noncompliance and the monitoring team concurred with the self-assessment. To continue to move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Rationale in the pre-ISP process for therapist attendance or non-attendance at the ISP needs to be sound and clearly supported. 2. Representation by OT and/or PT should be reconciled with the IDT during the pre-ISP process and should be consistent with the designation by the team. 3. Ensure that there is an assessment or consult that clearly establishes the need for OT/PT interventions and that states the goals and objectives. 4. Ensure that there is a clear discharge summary (in the IPNs). 5. OT and PT supports must clearly be outlined in the ISP. In the case that interventions are initiated outside the scheduled annual ISP, an ISPA must document initiation of the service, report progress and termination with rationale.	
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.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. <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.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. The facility did not have a current comprehensive OT/PT policy, that included all of the following elements and were in practice at the time of this review: • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria;	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Definition of the monitoring process for the status of individuals with identified occupational and physical therapy needs; • Definition of the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; • Identification of monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; • Identification of monitors and their roles and responsibilities; • Definition of a formal schedule for monitoring to occur; • Process for re-evaluation of monitors on an annual basis by therapists and/or assistants; • Requirement that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; • Identification of the frequency of assessments; • Definition of how individuals' OT/PT needs will be identified and reviewed; and • Requirements for documentation for individuals receiving direct services. <u>Monitoring System</u> • The facility did not implement a system for the adequate monitoring of PNMPs. Staff compliance monitoring for implementation of PNMPs and the condition and availability of adaptive equipment was monitored in a limited way in conjunction with effectiveness monitoring by the licensed OT and PT professional staff at MSSLC. No other compliance monitoring was conducted. There was a system established for routine effectiveness monitoring by the therapists using the compliance monitoring form with an additional IPN. These did not consistently address the overall effectiveness of all aspects of the PNMP, however. Effectiveness monitoring was conducted by the OT and PT clinicians via the same form used to monitor compliance. There was no designated section of this form that addressed the health risk interventions associated with the PNMP and/or Dining Plan, actual health events related to the risk concerns addressed by these plans and a judgment as to their effectiveness based on this. While monitoring in this manner was acceptable, there was no documentary evidence that this had been completed in the individual record. This was also not clearly referenced in the annual assessments. This element was self-rated to be in noncompliance and the monitoring team concurred with this finding. There was no comprehensive policy that outlined essential elements	

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		related to monitoring and OT/PT supports and services. There was no consistent system of staff compliance monitoring and effectiveness monitoring. This was reviewed further in sections O.6 and O.7 above. To continue to move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish benchmarks and a tracking system and schedule for quarterly effectiveness monitoring by OTs and PTs. 2. Conduct audits and staff training as to the process expected for effectiveness monitoring. 3. Address documentation of this monitoring to ensure that there is documentation in the individual record related to completion, findings, and further action(s) required. 4. Establish clear policies and procedural guidelines related to required activities to be completed by the therapy clinicians. 5. Further review and establish a system of staff compliance monitoring beyond that included in the effectiveness monitoring process.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/15/13 o MSSLC Organizational Charts o MSSLC Self -Assessment Section Q o MSSLC Action Plan Section Q o MSSLC Provision Action Plan o Presentation Book, Section Q o MSSLC Policy and Procedure Home Life and Training Policy #21 Oral Hygiene Care and Suction Toothbrush, Draft o MSSLC Organizational Management Manual Committees and Council, Desensitization Committee, 2013 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 Plans and Dental Progress Notes for the following individuals: • Individual #484, Individual #500, Individual #492, Individual #1 o Comprehensive Dental Records for the following individuals: • Individual #916, Individual #730, Individual #873, Individual #888, Individual #305, Individual #917, Individual #144, Individual #795, Individual #90, Individual #69 o Oral Surgery Consultations • Individual #649, Individual #493, Individual #43, Individual #517, Individual #850, Individual #224, Individual #242, Individual #798, Individual #242, Individual #109, Individual #98, Individual #72, Individual #227 Interviews and Meetings Held: o Jimmy Tompkins, DDS, Dental Director o Ricky Cross, DDS, Staff Dentist o Sandra German, Administrative Assistant o Christopher Ellis, MD, Medical Director Observations Conducted: o Dental Clinic o Dental Desensitization Meeting o Dental Clinic observation - Treatment of Individual #233

	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. This provision utilized a template for the self-assessment that was standardized and utilized at all SSLCs. It, therefore, covered the required items, which essentially reflected many of the items reviewed by the monitoring team. Even so, it appeared that some additional thought was needed in completing the self-assessment. For example, the dental clinic served a population of more than 300 individuals, but cited that the clinic's one dental policy was up to date. It would not be reasonable to consider that a healthcare delivery program servicing more than 300 individuals with a staff of more than six would operate with a single departmental policy. It also should have been noted that the data reported for oral hygiene in this self-assessment differed from data reported in previous self-assessments, which would make comparisons not possible. In moving forward, the dental director should read this report, noting the comments and recommendations. Future self-assessments should follow the template required by state office. Increased attention should be given to the quality of the information included. The facility rated itself in substantial compliance for both provisions. The monitoring team disagreed with the facility's self-ratings.
	Summary of Monitor's Assessment: There were several staffing changes in the dental department. The long time dental director retired in August 2013. The staff dentist assumed the position of dental director on 9/1/13. A new locum tenens dentist assumed the position of the clinic dentist. A new registered dental hygienist and dental assistant were also hired to fill vacancies opened by retirement of the long-term employees. Such significant changes in staff offered great opportunities for a reversal in the progress that was observed during the last visit. However, that was not the case. There were many changes implemented in the months just prior to the compliance review and the dental director acknowledged that the outcomes remained unknown. There were significant changes made in how direct care professionals were trained. The collaboration between the dental director and CTD to write SAPs for oral hygiene was ended and the frequency of completion of comprehensive assessments was changed. New portable x-ray equipment was purchased which should allow for increased compliance with obtaining radiographs. Overall, annual assessments were completed in a timely manner and the documentation found in these assessments was very detailed and thorough. Most individuals had recall visits on a quarterly basis. Routine prophylactic and restorative treatments were completed on campus and many individuals were referred off campus for more extensive treatment. MSSLC continued the practice of not utilizing mild sedation (anxiolysis) or any level of sedation. The facility was exploring the use of TIVA.

	There was still evidence of problems with oral care in the homes. Records documented individuals with evidence of poor home care. However, assessment of the overall state of hygiene in the facility was difficult based on the data provided. This will need to be addressed. The facility was taking new approaches to improve oral hygiene, such as implementing clinic programs for individuals with poor hygiene ratings and expanding the suction toothbrushing program. The failure rate increased slightly and a good number of failed appointments were due to missed appointments caused by scheduling conflicts and home visits. The facility addressed refusals through its desensitization committee. There appeared to be some success with the informal plans. There were four formal desensitization plans, two of which were relatively new. Overall, given the significant changes in the clinic, there was progress in the provision of dental services. In moving forward, the dental director will need to develop a comprehensive set of policies and procedures that outline all aspects of the provision of dental services.

#	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. <u>Staffing</u> There were several staffing changes in the dental department. The long time dental director retired in August 2013. The clinic dentist assumed the position of dental director on 9/1/13. A locum tenens dentist assumed the position of the clinic dentist. A new registered dental hygienist and dental assistant were hired to fill vacancies opened by the retirement of long-term employees. <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

	Apr	May	Jun	Jul	Aug	Sep	Oct
Preventive	--	137	125	113	113	117	201
Emergency	--	1	0	0	0	2	4
Extractions	--	4	3	0	2	1	0
Restorative	--	45	17	39	36	25	59
Total	--	228	175	193	189	174	308

There were also several off campus appointments to Scott and White for evaluation and

#	Provision	Assessment of Status	Compliance
		treatment by oral surgery and general dentistry. Emergency Care The clinic staff reported that emergency care was available during normal business hours. After business hours, the dental director was available by phone to discuss care with the primary providers. Radiographs The monitoring team discussed the requirement for radiographs with the dental director. He was aware that the facility had received the ADA guidelines from state office, but there was no specific frequency established for completion of radiographs at MSSLC. Generally, a set of full mouth x-rays was obtained every three years at MSSLC. The facility had acquired portable x-ray equipment just prior to the compliance review. MSSLC reported that 85% of individuals had current radiographs. The monitoring team found documentation of radiographs or attempts to obtain radiographs in the annual assessments reviewed. It is recommended that the dental director develop a policy related to dental radiographs that outlines the ADA's criteria based on risk assessment. Oral Surgery There were a number of referrals made to oral surgeons and general dentists at Scott and White. However, there was conflicting documentation submitted. Data from the medical department's database differed from that submitted by the dental department. The dental department was requested to submit the consults for all individuals with off campus appointments. This simple request was made complicated by referring the monitoring team to various sections of the document request. It also may have resulted in some non-extraction consults, which were required, being omitted. Nonetheless, many consults were not submitted. For example, there was evidence that individuals saw an oral surgeon in one submission, but the consult was not there, just the facility follow-up note. In other submissions, an initial consult was found, but the follow-up consult and operative reports were not. The facility note often clearly indicated that the work done differed from the work initially proposed. The monitoring team also noted that MSSLC documented in the facility listing that information regarding treatment from Scott and White was not available - "No Information in the Active Record." It is not clear how dental treatment at MSSLC could be continued if treatment at Scott and White was not known. Documentation of unknown information was noted multiple times. That information should have been obtained and assistance should have been sought from the medical director if necessary. A review of the presentation book included an email dated 10/2/13, sent to multiple	

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		individuals stating, "From now on when one of the individuals returns from oral surgery can you please fax any instructions or notes that come back with the individuals. DOJ wants to know that the dentist here has reviewed these and at this point dental isn't getting them at all." It would appear that the MSSLC dentist would review this information as a matter of good clinical practice. The effectiveness of the email was not reported. It appeared that the majority of individuals were seen off campus for multiple extractions of non-restorable teeth, some with rampant decay. Other individuals had extraction of third molars. There were also some individuals who had extraction of a single tooth. Follow-up generally occurred in the MSSLC dental clinic. Hence, there was a need for information related to treatment. <u>Oral Hygiene</u> The facility continued to monitor the oral hygiene ratings of the individuals. The following data were reported in the self-assessment: Oral Hygiene Ratings 2012 -2013 | | % | | Good | 44 | | Fair | 51 | | Poor | 4 | The data reported above reflected assessments of 2,471 individuals. Clearly, this included repeat exams for many individuals. Using this sample would not result in valid data. There were also data presented on the number of individuals each quarter, but these data were not paired with the census figures at that time. Hygiene at the facility may very well have been improving, but the data presented could not be used to reliably make that determination. The records continued to document individuals coming to clinic with heavy buildup of calculus and oral debris. The dental director made a number of changes in training related to oral hygiene. New employee training was conducted in clinic. Beginning in the middle of October 2013, the clinic began randomly selecting direct support professionals who attended clinic to demonstrate proper oral hygiene techniques in clinic. A more objective plaque index score was now being utilized along with new techniques for identification of problem areas. In addition to the random skills demonstrations, individuals with poor oral hygiene were required to have weekly recalls in clinic until they demonstrated two to three weeks of fair or good oral hygiene ratings at which time they were placed on a two to three month	

#	Provision	Assessment of Status	Compliance
		recall. If there was no improvement, the dentist wrote an order to have the IDT meet to discuss further interventions. The SAPs that were being written during the last review had been discontinued. <u>Suction Toothbrushing</u> Thirty-two individuals received suction toothbrushing. The monitoring team received the draft version of the suction toothbrushing policy. It was, however, approved at the time of the compliance review. The dental director explained that the PCP identified individuals at risk, such as individuals with a history of pneumonia and individuals who received enteral nutrition. The primary provider was responsible for writing the orders to implement toothbrushing. The policy did not provide this level of detail. The treatments were provided by the direct support professionals. A facility licensed vocational nurse was assigned the responsibility of training the staff and ensuring that the treatments were properly done. <u>Staff Training</u> All new staff received competency-based training, which now occurred in clinic. An annual oral hygiene refresher was available online through iLearn. Annual training was mandatory. The dental director also implemented random demonstration and training in clinic for direct care professionals. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: • The facility must continue to address the issue of oral hygiene. MSSLC must have a valid and reliable system for assessing the status of oral health of individuals. • MSSLC must ensure that practice for obtaining radiographs is consistent with guidelines issued by state office. This should be included in policy and procedure. • The dental director should address the issues noted above related to documentation from Scott and White. • The suction toothbrushing policy should be revised to clearly outline the program. Consideration should be given to how individuals will be identified to ensure that all potential candidates are assessed.	

#	Provision	Assessment of Status	Compliance
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	<u>Policies and Procedures</u> The monitoring team requested all policies related to the provision of dental care. The only policy submitted was a draft of the suction toothbrushing policy. The dental director indicated it was approved at the time of the review. The dental department needs to have a dental department manual that includes all policies, procedures, and guidelines involving the provision of dental services to ensure that all aspects of dental services are covered. That manual should be readily retrievable and available for review by staff. Topics should include, but not be limited to: • General operations of clinic and staffing • Informed consent • Dental radiographs • Oral hygiene tracking • Dental recall • Dental sedation • Anesthesia - medical clearance, recovery • General anesthesia personnel • Infection control • Training • Dental emergencies • Oral care Local policies should be updated to reflect changes in state dental policies. The department should also ensure that policies are reviewed on an annual basis and updated as required. <u>Dental Records</u> Dental records consisted of IPN entries, dental progress notes, treatment plans, and the dental record comprehensive examination. The entries made in the dental progress notes were done in SOAP format and were typed. For each DPN, there was an identical IPN entry. One problem the monitoring team found with documentation was the use of the active record for issues not directly related to care. For example, for Individual #305, the following entry was noted for the individual who had a "3:30 pm appointment. Is there a reason why they would not have let me known sooner? I would appreciate any insight that you could give me so this would not be an issue in the future." It was not appropriate to include this type of entry in the record of the individual. Documentation of the missed appointment in the record was appropriate, inclusion of the other statements was not. This was not an uncommon occurrence.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Annual/Comprehensive Assessments In order to determine compliance with this requirement, a list of all annual assessments completed during the past six months, along with the date of previous annual assessment, was requested. Assessments completed within 365 days of the prior assessment were considered to be in compliance. The available data were used to calculate compliance rates that are summarized below.	

Annual Assessment Compliance 2013						
	May	Jun	Jul	Aug	Sep	Oct
No. of Exams Completed	56	36	70	45	31	51
% Timely Completion	98	100	100	97	100	96

The overall compliance for the six-month reporting period was 98%. There was also improvement in the quality of the assessments. The facility was no longer completing comprehensive annual dental assessments every six months and there was no requirement to do so. Individuals continued for have frequent recalls for routine assessments.

The complete dental records were submitted for 10 individuals. Records included the annual exams, dental progress treatment records, and IPNs. The following is a summary of information found in the annual assessments (exams):

- 10 of 10 (100%) assessments included an entry on cooperation/behavior
- 10 of 10 (100%) assessments had entries for oral hygiene and periodontal conditions
- 10 of 10 (100%) assessments included documentation of oral cancer screenings
- 10 of 10 (100%) assessments included documentation that oral hygiene recommendations were provided to the individual and/or staff
- 10 of 10 (100%) assessments documented the risk rating
- 10 of 10 (100%) assessments documented x-rays or the need for x-rays.

For the records submitted, all of the documentation done by the dental providers was that of the dental director. Each assessment summarized the services provided, the exam findings, types of x-rays completed, and any abnormal x-ray results. The plan of care was outlined along with the rationale, when appropriate. Overall, the documentation for the assessments was good and provided the necessary information for the IDTs.

Generally, for the records reviewed, individuals were evaluated and treatment plans were formulated. Many individuals required additional work, such as restorations and sealers, which required consent. In most cases, within one to three months, the treatments were completed.

#	Provision	Assessment of Status	Compliance
		Initial Exams The facility submitted data for 32 individuals admitted since the last onsite review. Thirty-two of 32 (100%) individuals completed initial dental evaluations within 30 days. Failed Appointments The guidelines issued by state office required reporting of missed appointments and refusals. A missed appointment was one that was not attended by the individual because of reasons beyond his or her control. Refusals were appointments not attended because the individual stated he or she did not want to go. The failed appointments were the total number of missed appointments and refusals. The numbers as identified and reported by MSSLC are summarized in the table below:	

Failed Appointments 2013

	Apr	May	Jun	July	Aug	Sep	Oct
Missed	--	22	15	23	24	20	28
Refused	--	19	15	18	14	9	15
Failed	--	41	30	41	38	29	43
% Failed	--	18	17	21	20	16	13
Total Appointments	--	228	175	193	189	174	308

The failure rate for the reporting period was 17.5%. This was actually an increase from the 15% noted during the previous review. The greatest number of missed appointments was due to conflicting appointments and home visits. It would appear that addressing the scheduling of appointments would resolve many of the missed appointments. Other causes of missed appointments were a lack of records and a lack of staff.

Dental Restraints
MSSLC did not utilize any pretreatment sedation on campus for dental procedures. Several individuals were sent off campus for treatment where various types of anesthesia were utilized inclusive of anxiolysis and general anesthesia. As previously noted, MSSLC documented that, in many cases, information was not available, therefore, data on the number of times the various forms of anesthesia was used would clearly not be accurate.

The dental director reported that the facility was in the early planning stages for the implementation of TIVA. Discussions had occurred with a local dental anesthesiologist. The dental director planned travel to another SSLC to observe the current program in place for use of TIVA.

Strategies to Overcome Barriers to Dental Treatment
The dental director distributed data related to missed appointments and oral hygiene

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		status at the end of each day. This information was discussed in the unit meetings. When an individual refused treatment two or three times, the dentist wrote an order to have the IDT develop strategies to address the refusals. 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. There were four 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. The records of the four individuals were reviewed. Individual #484 was noted to have 10 areas of decay that needed restoration, but little progress occurred with the desensitization plan implemented in July 2013. Individual #500 and Individual #492 had plans implemented in February 2013. No significant progress was documented. The records for Individual #1 noted that oral hygiene improved since a formal desensitization plan was implemented in October 2013. 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 desensitization plans. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The dental director must proceed with developing adequate policies and procedures for the department as discussed above. 2. The scheduling conflicts should be addressed. 3. Individuals who are not making progress with desensitization plans and who are in need to dental treatment should be evaluated for alternative approaches. 4. The dental and medical directors should develop policies and procedures related to the use of TIVA and sedation in the dental clinic ensuring that nursing services is involved in the planning process.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Admissions List o Budgeted, Filled and Unfilled Positions list, Section I o Section R Presentation Book o Facility Self-Assessment, Action Plans and Provision of Information o Current SLPs, license numbers, caseloads o Continuing education and training completed by the SLPs since the last review o Facility list of new admissions since the last review o List of individual with PBSPs 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 Monitoring form template o Monitoring forms submitted o Summary reports or analyses of monitoring results o NEO Communication Training Curriculum o Communication Assessment for individuals recently admitted to MSSLC: Individual #895 and 990 o Communication Assessments, ISPs, ISPAs, SAPs and other documentation related to communication for the following individuals: • Individual #321, Individual #455, Individual #436, and Individual #795. o Communication Assessments, ISPs and ISPAs for the following individuals: • Individual #1, Individual #279, Individual #795, Individual #441, Individual #377, Individual #434, Individual #577, Individual #143, Individual #492, Individual #231, Individual #45, Individual #297, and Individual #492 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #427, Individual #216, Individual #266, Individual #80, Individual #503,

	Individual #220, Individual #376, Individual #43, Individual #407, Individual #588, Individual #310, and Individual #293. o PNMP section in Individual Notebooks for the following: • Individual #427, Individual #216, Individual #266, Individual #80, Individual #503, Individual #220, Individual #376, Individual #43, Individual #407, Individual #588, Individual #310, and Individual #293. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #427, Individual #216, Individual #266, Individual #80, Individual #503, Individual #220, Individual #376, Individual #43, Individual #407, Individual #588, Individual #310, and Individual #293. <u>Interviews and Meetings Held</u>: o Sandra Opersteny, PT Interim Habilitation Therapies Director o Lisa Finley, COTA o Sheri Morytko, MS, CCC-SLP o Teresa Koppang, MS, CCC-SLP o David Ehrenfeld, MSEd, CCC-SLP o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o ISP Meeting for Individual #160
	Facility Self-Assessment: The self-assessment continued to be thorough, though it did not always relate to the elements reviewed by the monitoring team. Findings were reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. Despite this, the facility requested reduced monitoring of all elements of Section R. This was accomplished by summarizing activities reported and reviewing the status with a small sample only. As such, all areas were found to be in noncompliance by the facility and 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 continued, but limited progress toward substantial compliance in all aspects of provision R. Efforts to improve the content of communication assessments were noted. Though there were some improvements in assessment content, on-time completion of assessments continued to be problematic. There had been improvements noted in previous months, by report, there had been a more recent decline in timeliness over the last month before this onsite review. There were few communication plans and SAPs in place for individuals with communication needs and for those with behavioral concerns in combination with severe communication deficits. Collaboration between psychology and SLPs appeared to be limited and no SLP had attended any Behavior Support Committee meetings. Continued effort was indicated to ensure integration of the recommendations in the communication assessment into the PBSP. This was also needed related to the ISPs as well. <u>The following samples were used by the monitoring team:</u> • Sample R.1: 21 individuals included in the sample selected by the monitoring team (best and most current assessments submitted by the facility for each clinician). • Sample R.2: Individuals admitted since the last compliance review. • Sample R.3: Individuals receiving direct speech services

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Staffing</u> The previous Director of Habilitation Therapies, Jessica Barry, MS, CCC-SLP was no longer with MSSLC and an Interim Director, Sandra Opersteny, PT, had been appointed in early November 2013. It was reported that there were five other full time SLPs with responsibilities related primarily to communication, but who also shared responsibilities related to mealtime and dysphagia with OT. They were Sheri Morytko, MS, CCC-SLP, Kathleen McKeown, MA, CCC-SLP, Teresa Koppang, MS, CCC-SLP, David Ehrenfeld, MSEd, CCC-SLP, and Karen Davila, MS, CCC-SLP. Ms. Davila was on leave at the time of this review and Ms. McKeown was no longer employed at the facility. There were two SLPAs, Marques Bradley and Suzanne Matteis. Teresa Koppang was the core SLP PNMT member as of August 2013 and had reduced caseload responsibilities (Martin 7 and 8) and was responsible for assessment of individuals newly admitted to the facility. There were five budgeted positions for speech language pathologists, with two filled by full time state employees and three others filled by contractors. Unfilled state positions	Noncompliance

#	Provision	Assessment of Status	Compliance
		were listed as three. A ratio of 5:325 was identified (current census was 322 at the time of this review) or 1:64. While this ratio was acceptable, the actual ratio was higher at the time of this review due to the current staffing of only three SLPs (1:107) and two SLPAs (1:161). A third SLPA position was identified in the Department Roster submitted in the Presentation Book for this section. A recruitment log listed activity related to review of resumes and interviews for available positions. Responsibilities of the therapists included, but were not limited to, conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs related to both communication and dysphagia. The speech staff were assigned caseloads as follows (totals based on individual list by home and based on census of 322): • David Ehrenfeld: Barnett, Whiterock, Longhorn, and Shamrock and included both dysphagia/mealtime and communication issues for these individuals (approximately 236 individuals). • Sheri Morytko: Martin 1-6 (approximately 69 individuals). Her responsibilities in these homes included both dysphagia/mealtime and communication issues for these individuals. • Teresa Koppang: Martin 7 and 8 (approximately 17 individuals). Her responsibilities in these homes included both dysphagia/mealtime and communication issues for these individuals, as well as serving as a core team member of the PNMT and responsible for completing assessments of individuals newly admitted to MSSLC. • Marques Bradley and Suzanne Matteis: All homes (approximately 322 individuals). They provided assistance and supports to the SLPs in all homes (as required and directed by the SLPs). There was a list of individuals with the calendar years for re-assessment, though assigned priorities related to the severity of individual communication deficits and communication assessment/support needs were not listed. It could not be determined from this list if all individuals had previously received a comprehensive assessment. Per the process in place, when a Comprehensive Evaluation was completed, an Assessment of Current Status was subsequently completed on an annual basis for individuals who were provided supports and services. Repeat Comprehensive Evaluations were recommended and completed on a prescribed interval (every three to five years) as designated in the communication assessments. Per the plan submitted, there were 69 individuals listed as requiring a re-assessment with 49 of those due in 2014, 16 in 2016, and four in 2017.	

#	Provision	Assessment of Status	Compliance
		The list of individuals with behavioral concerns submitted contained 283 individuals with 159 listed with PBSPs (56%). Fifty-nine of these individuals were identified with severe to profound language deficits (nonverbal and limited verbal). Fourteen of these had PBSPs. Another list identified 232 individuals with PBSPs and replacement behaviors related to communication. Based on the information submitted, it was not clear that the facility had clearly established the extent of communication needs for individuals in order to establish staffing needs. <u>Qualifications:</u> • License numbers were provided for all professional staff though these were not validated by the monitoring team due to this reduced review. <u>Continuing Education:</u> Based on a review of continuing education completed since the previous review: • 2 of 5 current speech staff (40%) had completed continuing education related to communication since the previous review. Two other staff had attended related conferences, but were not working at the time of the review. Two others had attended dysphagia related courses, but none related to communication during the last year. Only the SLPA (Matteis) had documented approximately 12 hours related to communication. No staff attended continuing education related to AAC per the documentation submitted. Continuing education attended by the clinicians for which contact hours or CEUs were provided that appeared to be potentially relevant to communication included: • Brain Injury: Practice Guidelines, 8 contact hours (Matteis) • Functional Therapy in Geriatric Care for SLP, 4 contact hours (Matteis) • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (Morytko) The intent of ongoing continuing education is to ensure that the clinicians attain and/or expand their knowledge and expertise related to the provision of communication supports and services, particularly related to AAC. The clinicians are encouraged to continue to seek continuing education courses beyond in-house training to continue to enhance their talents relative to the provision of communication supports and services. Inservices conducted by co-workers following attendance at formal continuing education courses is an excellent method to conserve resources, yet permit all staff to benefit from the information acquired. A system to track participation in continuing education was in place at MSSLC.	

#	Provision	Assessment of Status	Compliance
		Facility Policy: There was no local policy related to communication. The local policy should generally provide clear operationalized guidelines for the delivery of communication supports and services: • Roles and responsibilities of the SLPs. • Outlined assessment/update schedule including frequency and timelines for completion of new admission assessments, timelines for completion of Comprehensive Assessments, and timelines for completion of Comprehensive Assessment/Assessment of Current Status and assessments for individuals with a change in health status potentially affecting communication. • Criteria for providing an Assessment of Current Status versus a Comprehensive Assessment. • Addressed a process for effectiveness monitoring by the SLP. • 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. The monitoring team concurred with the self-assessment of noncompliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish a local policy that outlined the elements listed above. 2. Clearly establish the level of communication supports and services needs for the individuals living at MSSLC. 3. Establish a process for determining staffing to meet those identified needs. 4. The SLPAs were licensed to provide supports and services in the area of communication, but there were very few individuals provided direct therapy or AAC supports at the time of this review. Their roles should be clearly outlined, as well as, the roles of the supervising SLPs. 5. Ensure that all speech therapists participate in communication-related (particularly AAC) continuing education applicable to individuals with developmental disabilities to promote an understanding of their role in the provision of supports and services to the individuals living at MSSLC.	

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R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Assessment Plan:</u> The SLPs at MSSLC completed a Comprehensive Communication Evaluation for individuals as indicated. Individuals newly admitted were screened for communication needs and if these were identified, a comprehensive assessment was completed at that time. At the time of this review, some changes had been made to the standard format for these reports per the state office and were to have been implemented as of 10/1/13. Completion of assessments was based on the ISP schedule and re-evaluation was conducted on an interval to be designated in the evaluations. Assessments of Current Status were to be completed for individuals who received supports and services in years that a Comprehensive Evaluation was not required. Assessment due dates and timeliness of completion were tracked in the tracking log for individuals from 3/19/13 through 9/12/13 only. There were approximately 113 individuals listed as provided an annual communication assessment (at least 16 of these were new admissions since 6/1/13). Of those listed, only 59% had been completed on time, or within 10 days prior to the ISP. <u>Assessments Provided</u> One or two of the best and most current assessments for each speech clinician only were requested for review based on proposed reduced monitoring for this element. Communication assessments were submitted as follows: • Speech Pathology Baseline Assessment 1. Individual #1 (9/14/10) 2. Individual #279 (3/30/11) 3. Individual #795 (8/9/13) 4. Individual #220 (8/27/13) 5. Individual #441 (2/23/09) • Speech Pathology Comprehensive Assessment 1. Individual #377 (6/19/13) 2. Individual #434 (7/6/13) 3. Individual #577 (7/19/13) 4. Individual #143 (10/29/13) 5. Individual #492 (7/17/12) 6. Individual #231 (11/30/11) 7. Individual #45 (8/17/12) 8. Individual #297 (10/11/11)	Noncompliance

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		• Assessment of Current Status 1. Individual #441 (11/17/13) 2. Individual #297 (7/31/13) 3. Individual #45 (7/10/13) 4. Individual #231 (9/12/13) 5. Individual #492 (6/26/13) • 11 of 13 individuals (85%) in Sample R.1 were provided an assessment or update current within the last 12 months. • 28 of 28 individuals (100%) listed as admitted between 6/1/13 and 11/5/13 received a communication assessment and/or screening. Only one was identified as not completed within 30 days of admission (Individual #944) and one other was identified as within the 30 day time period, but was submitted after the due date established by the facility (Individual #918). • 9 of 11 individuals (82%) for whom assessments/assessments of current status (current within the last 12 months) were dated as having been completed at least 10 working days prior to the annual ISP. Though screenings were reported to be completed for individuals newly admitted, only one was submitted (in the Presentation Book) and none were included in the assessment tracking log. • If screenings were completed, 1 of 1 individual identified with therapy needs through a screening (100%), received a comprehensive communication assessment within 30 days of identification. <u>Communication Assessment:</u> Based on review of the sample of assessments submitted and included in Sample R.1, there were six individuals with current comprehensive assessments (Individual #143, Individual #577, Individual #434, Individual #377, Individual #795, and Individual #220) and these were included in the analysis below. None of these were completed by Mr. Ehrenfeld and only one of these was completed by staff currently working at MSSLC at the time of this review (Koppang), however. None of the assessments reviewed had all of the essential elements necessary for an adequate comprehensive communication assessment as identified by the monitoring team. The current state and local MSSLC assessment format and content guidelines generally required that these elements be contained within the assessments. The comprehensiveness of the communication assessments were as follows: • 6 of 6 assessments (100%) were signed and dated by the clinician upon completion of the written report. This was an improvement from 90% in the	

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		previous review. • 6 of 6 assessments (100%) included diagnoses and relevance of impact on communication. This was improved from 30% in the previous review. • 5 of 6 assessments (83%) included individual preferences and strengths. This was a decrease from 90% in the previous review. Though these were listed in some assessments, they were not used to guide the development of communication strategies or AAC systems. • 1 of 6 assessments (17%) included medical history and relevance to communication. This was an improvement from 0% in the previous review. The clinicians should consider including pertinent past medical history and current health status over the last year, with better analysis of whether the individual's function was impacted as a result. • 4 of 6 assessments (67%) listed medications and discussed side effects relevant to communication. This was generally consistent with the previous review (70%). • 5 of 5 assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels. This was an improvement from 0% in the previous review. This element required the clinicians to determine whether any areas of risk would be impacted by the individual's communication skills or whether there was any other relationship between communication and areas of risk, such as challenging behaviors. Further, the inability to express the specific source of pain or discomfort, for example, would require special supports to ensure that staff could interpret other behaviors that might provide clues for intervention. • 4 of 6 assessments (67%) 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 an improvement from 40% in the previous review. • 4 of 6 assessments (67%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was an improvement from 0% in the previous review. • 4 of 4 individuals' communication assessments (100%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required. This was an improvement from 0% in the previous review. • 4 of 6 individuals' communication assessments (67%) included discussion of the expansion of the individuals' current abilities. This was an improvement from 13% in the previous review. • 3 of 6 individuals' communication assessments (50%) provided a discussion of the individual's potential to develop new communication skills. This was an improvement from 11% in the previous review.	

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		• 2 of 5 assessments (40%) included the effectiveness of current supports, including monitoring findings. This was a decrease from 40% in the previous review. Individual #795 appeared to have been a new admission and, as such, had not previous supports, though this was not clearly stated in the assessment. • 2 of the 6 assessments (33%) 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 was an improvement from 0% in the previous review. • 2 of 5 assessments (40%) offered a comparative analysis of health and functional status from the previous year. This was an improvement from 0%. • 3 of 5 assessments (60%) gave a comparative analysis of current communication function with previous assessments. This was consistent with the previous review. • 4 of 6 assessments (67%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was generally consistent with the previous review (70%). • 5 of 6 assessments (83%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. This was a slight improvement from 80% in the previous review. • 6 of 6 assessments (100%) had a reassessment schedule. This was consistent with the previous review. • 3 of the 6 assessments (50%) supplied a monitoring schedule. This was an improvement from 20% in the previous review. • 3 of 6 assessments (50%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems. This was an improvement from 20% in the previous review. • 6 of 6 assessments (100%) made a recommendation about community referral and transition. This was consistent with the previous review. • 2 of 6 assessments (33%) included specific recommendations for services and supports in the community. This was a slight improvement from 30% in the previous review. • 5 of the 6 assessments (83%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was an improvement from 30% in the previous review. Additional findings related to the communication assessments were as follows: • 1 of 6 assessments (17%) contained 90% or more of the 23 elements listed above. • All others remained below 80% compliance, with an average of 68% overall. • Six elements were noted to be present in 100% of the assessments reviewed.	

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		Two elements were present in over 80% of assessments. All others were noted in less than 70% of the assessments reviewed. • Improvements from the previous review were noted for 65% of the 23 elements. • Six elements remained consistent with the previous review, three of those at 100%. • Decreases were noted for only two elements. A system of assessment audits implemented by the department for the establishment of competency of the speech clinicians was established though it was not clear how these would be conducted in the future. Self-assessment could be a viable alternative to review by leadership at such time as all clinicians have clearly established competency and compliance with the elements described above. Findings based on this audit system were unclear in the self-assessment. A report of Speech Therapy Annual Assessments in Compliance was submitted in the Presentation Book, but it was not clear if this referenced compliance with the essential elements reviewed by the monitoring team or reflected the findings of self-audits or related to the timeliness of assessments 10 working days prior to the ISP. There was a sample self-audit submitted in the Presentation Book in which the clinician found herself 100% compliant with the indicators listed, though these did not correlate fully with those used by the monitoring team. • 5 of 5 updates submitted in Sample R.1b (100%) were completed consistent with the established schedule, or the individual's need. Additional records were reviewed for Sample R.1a, and updates or Assessments of Current Status had been completed for four individuals within the last 12 months (Individual #293, Individual #43, Individual #80, and Individual #427). There was no evidence of a previous Comprehensive Assessment completed for any of these contained in their individual records as submitted, however. In the case of Individual #588, a Comprehensive Assessment had been completed on 11/6/12, but no further assessment was recommended until 2015 per the SLP. All others had been provided a Comprehensive Assessment within the last year. • 5 of 9 updates (56%) had an associated comprehensive assessment that was consistent with the established format and content guidelines. <u>SLP and Psychology Collaboration:</u> There were 59 individuals identified with behavioral issues and co-existing severe language deficits (nonverbal or limited verbal skills). There were 234 individuals listed with PBSPs who also had replacement behaviors related to communication. This was a significant increase since the previous review.	

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		There were approximately 45 meetings held to review PBSPs from 5/6/13 through 10/29/13 and no speech representative attended any of the meetings held. Participation in the review of PBSPs during these meetings was a missed opportunity to promote collaboration between psychology and the SLPs. It is understood that collaboration for assessment and development of PBSPs and communication plans may need to occur prior to the time of review by the Behavior Support Committee and, in that case, the facility is encouraged to document those efforts. Further it is encouraged that the facility ensure that there was adequate integration between the PBSP and the communication assessment. There was an inadequate discussion of the relationship between communication deficits and identified behavioral challenges in the communication assessments included in the samples reviewed. Progress was made in this provision. The facility had requested reduced monitoring for this provision and had self-rated noncompliance. The monitoring team concurred based on the findings reported above. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Develop a plan, to include benchmarks to address the completion of communication assessments for individuals in a timely manner, while not reducing the current supports and services provided. 2. Initiate further collaboration with psychology to identify strategies to ensure integration of communication strategies in the PBSPs, including regular participation in the Behavior Support Committee. 3. Clarify the function of the Comprehensive Evaluations versus the Assessments of Current Status based on the forthcoming changes as to formats as required by the State. 4. If it is determined that the Assessment of Current Status is an update to an existing Comprehensive Assessment, ensure that the Comprehensive Evaluation is not purged from the record and is present in tandem with any subsequent updates until a repeat Comprehensive is completed. 5. If the Assessment of Current Status is intended to be a stand-alone document, documentation related to behavior and the PBSP should be included to ensure that the communication strategies and behavioral strategies are consistent and well-integrated. 6. Ensure that the essential elements for assessments identified above are addressed in all assessments by all speech clinicians. Consider seeking supports from other facilities in this regard, particularly related to the assessment and provision of AAC supports to individuals.	

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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.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Integration of Communication in the ISP:</u> • For 11 of 12 individuals in Samples R.1a (92%), a SLP was in attendance at the ISP. Pre-ISP documentation was not submitted as requested, but a number of the sign-in sheets designated whether a team member was required to attend. Based on these, a SLP was required to attend five. • For 3 of 12 individuals (8%), communication strategies identified in the assessment were included in the ISP. • In 11 of 12 ISPs for individuals with communication supports (92%), the type of AAC and/or other communication supports (e.g., Communication Dictionary) were identified. As described above, strategies for staff use were not provided in many cases. • Communication Dictionaries for those who had them were reviewed at least annually by the IDT for 0 of 12 (0%), as evidenced in the ISP. Some only mentioned the dictionary as a support, but did not reflect IDT review. • 3 of 12 ISPs (8%) included a description of how the individual communicated and how staff should communicate with them. The ISP consistently described how the individual communicated, but did not consistently include how staff should communicate with them. • 4 of 12 ISPs (33%) contained skill acquisition programs to promote communication, though most presented with significant language deficits. • Information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP as these supports were not in place for review in the ISP. <u>Individual-Specific AAC Systems:</u> Approximately 18 individuals were listed with one or more types of communication systems. These systems were generally portable, functional, and individualized. Most had been in place for a number of years with only one individual provided a system in the last two years (Individual #38). There were 19 individuals listed as participating in direct communication therapy intervention at the time of this review. Most were related to articulation or stuttering (16), while the others were to address expressive and receptive language. None appeared to be related to the provision of AAC. There were five individuals with environmental control devices and one listed with a chewy tube, though it was not clear how that related to communication or environmental control.	Noncompliance

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		Communication dictionaries were also provided for approximately 82 individuals at MSSLC. This was the primary communication support offered. The communication dictionary is not considered AAC, but rather a reference for staff to interpret common communication efforts by the individual. This enhanced staff understanding of the individual and promotes consistent responses, but did not specifically enhance or improve the individual's expressive or receptive skills. These were identified in the assessments and, in most cases, reviews of the effectiveness of these tools were addressed in the samples. A significant number of individuals presented with communication deficits and were likely to benefit from additional communication supports to enhance and improve their skills. The majority of the assessments for the individuals in the samples reviewed did not provide an adequate assessment of the individual's potential for AAC use. For example, in the case of Individual #285, the communication assessment dated 1/4/13, did not include an AAC assessment, but rather recommended that one be completed. There was no reason this should not have been done during this annual assessment. Significant direct intervention and trials occurring in the natural environment (in situations that were most meaningful to the individual) should be utilized to identify appropriate AAC with the consistent use of training/teaching models to expose and promote interest and use of AAC across settings with attempts made for use in settings over time in order to spark interest, such as to request a favorite item, food, beverage, music, vibration, or massage, for example. <u>General Use AAC Devices:</u> There were a limited number of general use communication devices. None were seen in use during this review. <u>Direct Communication Interventions:</u> There were 19 individuals listed as participating in direct communication-related interventions. 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 a comparative analysis of the individual's progress or lack of progress.	

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		Records related to the provision of direct intervention for Individual #321, Individual #455, Individual #436, and Individual #795 were not included in the documents submitted for review (Sample R.3). This included assessments, ISPs, ISPAs, SAPs, and progress notes. Findings were as follow, however, this was based on a single individual, Individual #31. • 0 of 1 individual (0%), a direct intervention plan was implemented within 30 days of the plan's creation, or sooner, as required by the individual's health or safety. • For 1 of 1 individual (100%), the current SLP assessment identified the need for direct intervention with rationale. • For 1 of 1 individual (100%), there were measurable objectives related to individual functional communication outcomes included in the ISP. • For 1 of 1 individual (100%), the therapist reported clinical data to substantiate progress and/or a lack of progress with the therapy goal(s). • For 1 of 1 individual (100%), there was a description of the benefit of the device and/or goal to the individual. • For 1 of 1 individuals (100%), consistency of implementation was documented. • For 1 of 1 individuals (100%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. • The following metric was not rated as Individual #31 continued in direct therapy at the time of this review: For __ of __ individual for whom direct intervention had been discontinued, termination of the intervention was well justified and clearly documented in a timely manner. • 1 of 1 (100%) individuals receiving direct Speech Services (Sample R.4) were provided with comprehensive progress notes that contained each of the indicators listed below: o Contained information regarding whether the individual showed progress with the stated goal. o Described the benefit of device and/or goal to the individual. o Reported the consistency of implementation. o Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. o Completed at least monthly. Monthly summaries were consistently completed, providing a graph of actual performance, readily permitting an analysis of progress related to the measurable goals and objectives.	

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		Indirect Communication Supports: Indirect communication supports included PNMPs, communication dictionaries, and general use AAC. These supports were identified in the annual assessment and described in the PNMP, which provided clearly stated instructions for staff. Other indirect supports were developed in the form of SAPs implemented by DSPs in the day program or work areas, though these were very limited. Effectiveness Monitoring This type of monitoring should address communication plans and AAC, dictionaries, and SAPS related to other indirect communication supports. The frequency of effectiveness monitoring may be based on individual risk or the intensity of supports provided, but should be conducted no less than quarterly (the annual assessment may serve as the fourth quarter review), and clearly stated in the communication assessment. This should address any changes in risk or status of the individual since the previous review and staff compliance, as well as whether the supports and/or strategies effectively met the intended need. Frequency should be included in the ISP with documentation in the IPNs. These notes should include the following: • Previously unresolved issues • PNM Risk occurrences since the previous effectiveness monitoring that impact communication • Purpose and function of the device or support • Presence and condition of equipment • Staff knowledge and compliance • Analysis of program effectiveness including progress, regression and maintenance as well as if the plan remained current and appropriate • Identification of issues with recommendations for changes as indicated including the person responsible and timelines for completion There was still evidence of Activity Plans intended to provide quarterly monitoring of supports, though by report these had been discontinued some time ago. Though noted, effectiveness monitoring was not consistently conducted particularly in the area of communication. The system of using the monitoring form noted though an IPN was completed in the cases of those submitted, though the elements identified above were not consistently included. Competency-Based Training and Performance Check-offs: MSSLC had a system of comprehensive competency-based training regarding communication services. Training provided: • Opportunities for active participation and practice of the skills necessary for	

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		appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. • Skill performance check-offs that included a demonstration component to assess staff. Habilitation Therapies provided new employees with classroom training on foundational communication-related skills. Class time included two hours only to address deaf awareness and AAC. The content, based on review of the curriculum materials, was limited due to the brief period of time for presentation. This included instructional content and foundational skills, with modeling by the trainers, to new employees. New employees were required to take a combination of written tests and were checked off on specific skills, using the checklists. Employees were expected to pass all essential elements of the core competencies and written examinations. Check-offs were repeated until the employee passed these prior to assignment in direct care. By report, all staff had passed these at this time. The training materials reviewed addressed most of the appropriate minimum foundational content areas listed below: • Identification of nonverbal means of communication. • Strategies to enhance individual participation in routines throughout the day • How to be an effective communication partner • Methods to enhance communication • Implementation of communication plans and programs • Benefits and use of AAC The following metrics were intended to address the compliance with training as intended via the Settlement Agreement. • % of new employees had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review. • % of staff required to take the Annual Refresher class There was no refresher in the area of AAC/communication implemented at MSSLC. • There was/was not a system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators. <u>Individual-Specific Competency-Based Training</u> The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO, though these were very limited in the area of communication. The following metrics were intended to address the compliance with training as intended via the Settlement Agreement. • Per the system in place, % of the staff assigned to individuals in the samples	

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		selected by the monitoring team were trained related to the PNMP prior to the provision of services. • Per the system described, % of the staff assigned to individuals in the samples selected by the monitoring team had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) prior to the provision of services. • __ of __ staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. • The facility did or did not have a process to validate that staff responsible for training other staff are competent to assess other staff's competency. The facility self-rated noncompliance with this provision and the monitoring team concurred. Though somewhat improved, there was insufficient assessment of the AAC needs and the provision of these supports. The process of effectiveness monitoring was not conducted consistently. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish a system to track SLP attendance as described by the pre-ISPs. Negotiate identified errors before the ISP meeting. Guidelines for IDTs should be provided to assist them in making the determination as to whether an SLP was needed at the meeting and how to address the identified needs for assessment. 2. Address quality of implementation and documentation of direct and indirect supports as recommended. This should include routine effectiveness of all communication supports provided.	
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	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Compliance Monitoring of Implementation of Communication Supports</u> A system of compliance monitoring was established at MSSLC using a general Compliance and Effectiveness Monitoring form. The majority of these submitted related to supports not clearly related to communication. Compliance monitoring should address implementation of all specific communication plans (including AAC) and communication strategies across implementation of activities.	Noncompliance

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	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.	This may be also accomplished as the staff are engaging in other activities on the PNMP or implementing other SAPs. Equipment should be monitored for availability, condition, and working order with routine general check-offs for how to use the equipment. Communication dictionaries should be monitored for availability and whether staff understand how to use them. The facility concluded that they were not in compliance with this provision of section R and the monitoring team concurred as described above. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Review and revise the system of communication monitoring. The system may be broken down as needed to address specific outcomes as desired based on revision of the current processes in order to shape the system as needed. 2. Establish clear procedural guidelines for effectiveness monitoring and include documentation guidelines. 3. Consider review of the current compliance monitoring forms to ensure the indicators are those that capture the status of the current supports and accuracy of implementation. 4. Consider review of the process used for effectiveness monitoring. 5. Track findings of both effectiveness and compliance monitoring. Audit for timely completion of each as per the recommendations in the assessment. Ensure that these findings are included in annual communication assessments for individuals.	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Individual Support Plans (ISPs) for: • Individual #502, Individual #600, Individual #916, Individual #790, Individual #639, Individual #64, Individual #951, Individual #532, Individual #610, Individual #225, Individual #100, Individual #549, Individual #18, Individual #539 o Skill Acquisition Plans (SAPs) for: • Individual #502, Individual #600, Individual #916, Individual #790, Individual #639, Individual #562, Individual #377, Individual #424, Individual #224, Individual #451, Individual #104, Individual #40, Individual #990 o Monthly review of SAP progress for: • Individual #502, Individual #600, Individual #916, Individual #790, Individual #639 o Functional Skills Assessment (FSA) for: • Individual #502, Individual #600, Individual #916, Individual #790, Individual #639 o Preference & Strengths Inventory (PSI) for: • Individual #502, Individual #600, Individual #916, Individual #790 o Vocational assessments for: • Individual #502, Individual #600, Individual #916, Individual #790, Individual #639 o Advanced work behaviors assessment for: • Individual #916, Individual #790 o Self-administration of medication skills assessment for: • Individual #916 o Responsible Social and Sexual Behaviors Assessment for: • Individual #916, Individual #790, Individual #600 o Dental Desensitization plans for: • Individual #1, Individual #484 o ISPs, ARD/IEPs, attendance sheets, and progress notes for: • Individual #539, Individual #600, Individual #951 o Desensitization Committee agenda, 11/13/13 o A list of training conducted on skill acquisition plans, undated o Minutes from the Skill Acquisition Review Committee (SARC) meeting, 12/10/13 o List of Integrity check monitors, engagement monitors, and inter-rater monitors for engagement, undated o Graph of engagement data in November and December, 2013 conducted by the active treatment coordinators (evening shift) and engagement monitors (day shift) o Tracking log of functional skill assessments and vocational assessment from 6/13-11/13

	o A list of all instances of skill training provided in community settings o A list of all integrity scores for skill acquisition programs from 6/13-10/13 o Skill acquisition plan (SAP) implementation check form, 5/1/13 o A List of community outings per residence from 6/13-11/13 o Section S presentation book, December, 2013 o Section S self-assessment, 11/25/13 o Section S action plans, 11/25/13 o A list of individuals employed on-and off campus, undated o Description of on-and off-campus work programs, undated o Minutes of active treatment coordinators meeting, 10/23/13 o List of the most recently developed medical and dental desensitization plans, no date o List of all individuals under age 22 and their current public school placement <u>Interviews and Meetings Held</u>: o Barbara Shamblin, Director of Education and Training o Barbara Shamblin, Director of Education and Training and Janet LaFoy, Education and Training Program Compliance Monitor o Sandra Outlaw, Active Treatment Coordinator o Norvell Starling, MSSLC liaison to MISD o Longhorn unit QIDPs and managers, 6/6/13 <u>Observations Conducted</u>: o Desensitization Committee meeting o SARC meeting o Skill acquisition plan treatment integrity session for: • Individual #104 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. 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 monitoring team'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 several improvements since the last review. These included: • Increase in the number of SAPs written in the new format (S1) • New engagement monitoring tool (S1) • The establishment of individualized engagement goals for each residential unit (S1) • The establishment of a target engagement level for each residential unit (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) • Improvement in the effectiveness of SAPs (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, including SAM/HIP and dental desensitization 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 SAP plans for generalization and maintenance are individualized (S1) • Ensure that all behavioral objectives are individualized (S1, S3) • Establish target engagement levels for day treatment sites (S1) • Ensure that preference and strengths inventories (PSIs) are completed and available to team

	members at least 10 days prior to each individual's ISP (S2) • Document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of all skill acquisition plans (S2) • Establish target frequencies and levels of SAP integrity, and insure the achievement of those frequencies and levels are achieved (S3) • Establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that those levels are achieved (S3)

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item includes an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at MSSLC. Although there was progress since the last review, more work (discussed in detail below) is needed to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance. <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 and seven rehabilitation technicians. SAPs were implemented by education and training instructors and direct support professionals (DSPs). 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 preferences. 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. As discussed in the last report, the facility recently established 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 continued to be impressed with the quality of the reviews, and encourages the facility to continue to conduct these meetings. MSSLC recently developed a new SAP format to clarify the necessary components, and the training process. At the time of the onsite review, 74% of SAPs reviewed were in the new format. The only SAPs in the old format encountered by the monitoring team were the SAMS and HIP programs, and the systematic desensitization plans. This represented an improvement from the last review when only 50% of SAPs were in the new format. It is recommended that the new SAP format be expanded to all SAPs at MSSLC.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The monitoring team reviewed 29 SAPs across 13 individuals. Six of those SAPs were SAMS/HIP SAPs in the old format and, therefore, were not used in the evaluation of this provision item. In 16 of the 23 new format SAPs reviewed (70%), the rationale appeared to be based on a clear need and/or preference. This represented a decrease from the last review when 80% 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 #639's vocational SAP was that he wanted to work in the community, and needed to increase his functional work behaviors to achieve this goal. • The rationale for Individual #502's SAP of applying lotion to his feet included that he had dry skin and the lotion will decrease skin breakdown. 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 #916's SAP of money management stated he couldn't combine coins. 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 a rationale that is 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	

#	Provision	Assessment of Status	Compliance
		• 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 quality of some of these components was improved. All 23 of the SAPs in the new format reviewed (100%) included a plan for generalization that was consistent with the above definition. This represented an improvement over the last report when 80% of generalization plans were judged to be consistent with the above definition. Additionally, as reported in the last review, all of the new format SAPs reviewed (100%) included a plan for maintenance that was consistent with the above definition. One concern, however, was that many of the maintenance and generalization plans reviewed appeared very general and similar to one another. For example several maintenance plans included the following wording: • Once (the individual) has met mastery criteria in the area of training he will continue to receive reinforcement for engaging in the behavior on an intermittent schedule of reinforcement…. Similarly several generalization plans were similar and included: • (Individual) will apply his skills in any setting where the skill would functionally occur. These maintenance and generalization plans were technically correct, however, in order for them to be effective they should be individualized so that staff are more likely to correctly implement them. Therefore, it is recommended that all maintenance and generalization plans are individualized and are consistent with the above definitions. Additionally, although every SAP reviewed contained a behavioral objective, they were identical for all SAPs reviewed (i.e., independently achieve the SAP in 88% of the monthly test trials). As discussed in S3, in order for a behavioral objective to be most practical and useful, it needs to match each individual's goals and needs. It is recommended that all behavioral objectives be individualized. At the time of the onsite review, the facility used various training methodologies, including total task training and forward and backward chaining. <u>Dental compliance and desensitization plans</u> As discussed in the last review, desensitization plans designed to teach individuals to tolerate medical and/or dental procedures were developed by the psychology department. The psychology department had also developed an assessment procedure	

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		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 continued to meet regularly. The monitoring team observed this meeting, which 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 two 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 13 individuals reviewed (8%) had skill acquisition programs targeting the enhancement or establishment of communication and language skills. This was the same as the last review when 8% 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., brushing an individual's teeth). These were written and monitored by the master teachers or SAP writers. 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).	

#	Provision	Assessment of Status	Compliance
		Engagement in Activities As a measure of the quality of individuals' lives at MSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each home and day program is listed in the table below. The monitoring team was encouraged by the overall quantity of age appropriate and typical activities at MSSLC. In past reviews, the monitoring team has commented that many of the individuals were out of the homes, engaging in activities in appropriate outside activities on campus and in the community. During the current review, however, the weather was not conductive to outdoor activities. The monitoring team was pleased to note that although the majority of individuals were in the residences during the current review, the majority of individuals continued to be engaged in typical activities, such as doing homework, playing games, engaged in arts/crafts projects, listening to music, talking to friends, watching television, or socially interacting with staff. The monitoring team's average engagement score across the facility was 62%, the same as that observed during the last review. The facility continued to conduct its own engagement assessments. Since the last review MSSLC modified the method they used to collect engagement. At the time of the onsite review, the facility used a momentary time sample similar to that used by the monitoring team when they conduct engagement assessments. The facility's average engagement for November 2013 and December 2013 (since they modified their engagement collection procedure) was 61%, consistent with that collected by the monitoring team (62%). Additionally, MSSLC recently began to compare engagement data in day programs to those residential sites. Finally, MSSLC recently established individual engagement goals for each residential unit. The monitoring team is encouraged by these recent changes in engagement at MSSLC. At this point, it is recommended that engagement targets for day program sites be established, and the facility ensures that engagement targets for day program and residential treatment sites are achieved.	

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		Engagement Observations: Location / Engaged / Staff-to-individual ratio M1 & M2 common area 2/7 3:7 M3 3/7 2:7 M7 & M8 common area 4/6 2:6 S1 5/6 3:6 S2 5/6 3:6 B2 3/6 2:6 B6 1/3 1:3 B7 & B8 common area 4/6 2:6 B7 & B8 common area 4/5 3:5 L1 1/6 1:6 L1 2/6 2:6 L6 4/7 3:7 L6 5/7 3:7 L6 5/8 3:8 W9 1/2 1:2 W7 0/1 1:1 Step Center Classroom 6/6 3:6 Step Center Classroom 5/5 2:5 PAWS Workshop 6/7 1:2 M5 day program 2/2 0:2 M5 day program 4/7 2:7 M5 day program 2/4 1:4 M6 day program 4/5 3:5 M1 and M2 day program 4/8 1:8 Life skills 4/4 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 61 students were receiving educational services from Mexia Independent School District (MISD) compared to 74 and 68 at the time of previous reviews. All students continued to attend school at MISD school buildings in town. Most were at MISD's special education building (49), but others were at the regular high school (11) or at the regular junior high school (1). Most of the students lived in the Longhorn unit (54). Those students who were older than 18 years old lived at Whiterock (2), Shamrock (4), and Barnett (1).	

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		The MSSLC liaison to MISD reported a continued positive working relationship with MISD. MSSLC continued to send seven staff per day. The Longhorn unit QIDPs and managers also reported a very positive relationship with MISD. The liaison attended almost every ARD/IEP meeting and that sometimes others from MSSLC also attended. An SSLC student was "spotlighted" every month at the special education building program. The liaison also reported that the number of students with no discipline referrals was increasing. The MSSLC unit staff reported that they tried to do a dinner or outing for those students. The facility director reported that there had been zero school refusals so far this year for any student at MSSLC. All ISPs contained references to the individual's enrollment in public school and his ARD/IEP. Two of the three (67%) in the sample contained action plans or objectives related to what the student was learning in school (Individual #539, Individual #951). For example, Individual #539's ISP had action plans for using subtraction and for reading comprehension. All ARD/IEPs included multiple references to MSSLC and the student's residence at the facility. ARD/IEP reports cards and progress notes were reported to be reviewed by the QIDPs and noted in their monthly reviews, though no examples were provided. The behavioral services staff and the education and training staff reported that they mentioned the school report cards in their monthly progress notes, too. At the Longhorn unit meeting, MISD-related issues were regularly on the agenda. Data and reports regarding problem behaviors that occurred in school were reported to be included in the behavioral services data, graphs, and summaries. Further, issues that occurred at school were reported to be brought into group and individual therapies, as appropriate. The liaison also said that MISD discipline notes went to the psychology department, the education and training department, the unit director, and the QIDP.	
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.	Not all individuals reviewed had annual assessments of preference, strengths, skills, and needs. Additionally, although improving, only 52% of SAPs reviewed were clearly based on assessments, and there was no documentation that preference and strengths inventories were available to team members at least 10 days prior to each individuals team meeting. Therefore, this item was rated to be in noncompliance. To assess compliance with this item, the monitoring team requested Individual Support Plans (ISPs), Functional Skill Assessments (FSAs), Preference and Strengths Inventories (PSIs), and Vocational Assessments for five individuals. One individual reviewed (i.e.,	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #639) did not have a PSI, and another individual's PSI (i.e., Individual #916) was blank. These findings were consistent with the self-assessment that indicated that every individual had a FSA and vocational assessment, and 77% of individuals had a completed preferences and strengths inventory (PSI). All individuals should have assessments of preferences and strengths. Additionally, in order to be most useful for the selection and development of SAPs, assessments should be completed and available to team members prior to the ISP. Tracking data for FSAs and vocational assessments indicated that the majority (85% of FSAs, 88% of vocational assessments) were completed 10 days prior to the ISP. MSSLC did not provide tracking data for PSIs. As discussed in the last review, the FSA appeared to be an adequate tool for assessing 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 worn, whether the individual chooses them or not, etc. Similarly, surveys of preference can be very helpful in identifying preferences and reinforcers, however, there are considerable data that demonstrate that it is sometimes necessary to conduct systematic (i.e., experimental) preference and reinforcement assessments to identify meaningful preferences and potent reinforcers. There was no documentation of the use of individualization of assessment tools to identify SAPs in any of the FSAs reviewed. Overall, these five individuals had a total of 21 SAPs, and 11 of those (52%) had documentation that assessments were used to develop them. This represented an improvement from the last review when the majority of the SAPs reviewed did not include documentation that assessments were used to develop them. Examples of assessments that were used to develop SAPs included: • Individual #916's SAP to increase his knowledge of his medications was based on his preference to live independently in the community, and the results of his self-administration of medication skills assessment that indicated he could not safely manage his medications independently. • Individual #502's ISP and PSI indicated that he enjoyed buying items, however his FSA indicated he does not know how to determine what items cost. Based on his preference and need, a SAP to teach him to determine what items cost was developed.	

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		• Individual #600's PSI documented that he wanted to return to the community to live with his mother, however, his SAM assessment indicated that he could not safely self-administer his medications. Therefore, a SAP to learn to safely self-administer his medications was developed. Examples of SAPs where it was not clear how or if assessments impacted their development included: • Individual #790 had a money management SAP, however, there was nothing in his ISP, FSA, or PSI that suggested that this was a practical SAP for him. • Individual #639 had a SAP to improve his reading that included a rationale that he wanted to enhance his reading skills. No available assessments, however, indicated that improving reading was a preference for Individual #639. In order to achieve substantial compliance for this provision item, MSSLC needs to ensure that all individuals have assessments of individuals' preferences, strengths, skills, and needs that are completed at least 10 days prior to the ISP. Additionally, there needs to be documentation of how assessments were used to select the individual skill acquisition plans.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	MSSLC continued to make progress on this provision item, however, more work, discussed below, is necessary before it will be in substantial compliance. The master teachers and rehabilitation technicians at MSSLC wrote monthly progress notes and graphed SAP data to improve data based decisions as to continuing, modifying, or discontinuing individual SAPs. Six months of SAP reviews were requested for five individuals. Sixteen of the 21 SAPs reviewed had at least three months of data. Nine of those 16 SAPs (56%) indicated SAP progress. This represented an increase from the last review when 25% of SAPs reviewed showed progress. As found in previous reviews, there was evidence of data based decisions concerning the continuation, modification, or discontinuation of SAPs (e.g., Individual #916's vocational SAP, Individual #600's reading SAP). There were several SAPs reviewed, however, where individuals appeared to	Noncompliance

#	Provision	Assessment of Status	Compliance
		achieve their behavioral objective, but they continued to train on the SAP (e.g., Individual #916's money management SAP, Individual #790's self-administration of drugs SAP). In each case of SAPs continuing beyond the behavioral goal, the progress note indicated that the although the individual achieved the goal, the SAP would continue to ensure mastery. As noted in S1, the behavioral objectives for all of the SAPs reviewed were identical. It is likely that the training necessary to demonstrate mastery of a skill will vary across individuals and SAPs. Therefore, the behavioral objectives need to be individualized to match varying objective criteria of mastery. As in past reviews, the implementation of SAPs was observed by the monitoring team to evaluate if they were implemented as written. One SAP observed (Individual #104's reading sight words SAP), implemented in the day program, appeared to be conducted as written. The majority of SAPs at MSSLC are implemented in the day programs by education and training instructors. Some SAPs, however, are implemented in the residential units by DSPs. Future reviews will attempt to observe SAPs implemented in the residences. The monitoring team also observed a SAP integrity session. SAP 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 other question was "Is the SAP being implemented as written?" The self-assessment indicated that 83% of the SAPs from April 2013 to September 2013 were implemented as written. The monitoring team was encouraged by the level of SAP integrity data and the facility's commitment to ensure that SAPs are consistently implemented as written. In addition to attempts to improve SAP integrity, MSSLC continued to retrain integrity monitors to ensure that the data were reliable. Future reviews will attempt to assess if SAP integrity data are reliable across monitors, and to the extent that SAP integrity is assessed in the residence in addition to the day programs. Finally, 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. In order to attain substantial compliance, the facility needs to demonstrate that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs, and that SAP integrity (both in day programs and in the residences) attains established levels.	

#	Provision	Assessment of Status	Compliance
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at MSSLC enjoyed recreational and training activities in the community. The facility provided data indicating that from April 2013 to September 2013, 85% of all individuals participated in community outings. Additionally, since the last review, MSSLC developed a revised community-training database. It is recommended that the facility establish minimal acceptable levels of community recreational activity and community training per home. Additionally, the facility needs to ensure those levels of community recreational activities and training 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. In order to achieve substantial compliance with this provision item, the facility needs to establish minimal acceptable frequencies of recreational activities and community SAP training per home, and demonstrate these established levels are consistently achieved.	Noncompliance

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 018.2, 10/18/13, and exhibits and forms attachments o MSSLC facility-specific policies regarding most integrated setting practices • All AP department policies remained the same and were not re-reviewed. o MSSLC organizational chart, November 2013 o MSSLC policy lists, October 2013 o List of typical meetings that occurred at MSSLC, undated but likely November 2013 o MSSLC Self-Assessment, 11/25/13 o MSSLC Action Plans, 11/25/13 o MSSLC Provision Action Information, 11/20/13 o MSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 12/9/13 o Community Placement Report, last six+ months, 6/1/13 through 12/6/13 o List of individuals who were placed since last onsite review (29 individuals) o List of individuals who were referred for placement since the last review (36 individuals) o List of individuals who were referred <u>and</u> placed since the last review (2 individuals) o List of total active referrals (53 individuals) o List of individuals who requested placement, but weren't referred (132 individuals) • Documentation of activities taken for those who did not have an LAR (0) • Those who requested placement, but not referred due to LAR preference (8) o List of individuals who were not referred solely due to LAR preference (68 individuals, data were incorrect) o List of rescinded referrals (12 individuals, 1 occurred the week of the onsite review) • ISPA notes regarding each rescinding (11 of the 11) • Special Review ISPA Team minutes for each rescinding (8 of the 11) o List of individuals returned to facility after community placement (1 individual) • Related ISPA documentation (0) • Root cause analysis (0) 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 • There were about 60 individuals who moved, information was submitted for 24. 7 of these 24 individuals who moved since 12/1/12, i.e., 1 year since placement, and for whom the SSLC had information).

	• Completed Potentially Disrupted Community Transition forms (0) o List of individuals who died after moving from the facility to the community since 7/1/09 (18, 0 since the last review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (8 individuals) o APC Department meeting minutes, (none) o List and job descriptions for APD staff o APC weekly reports • Detailed referral and placement one-page report for senior management, (0) • Statewide one page weekly enrollment report (0) o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair • Community tours • Work with local LA (none) • Work with local providers (none) • Facility-wide staff trainings/activities • For families • Brochure and facility newsletter • CLOIP and PP tracking tools (none) o Description of how the facility assessed an individual for placement (none) 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) (none) o List of individuals who had a CLDP completed since last review (30) o DADS central office written feedback on CLDPs (none) o QA related activities • Section T QA reports • Set of 13 graphs on 6 pages o MSSLC referral information spreadsheet, for 48 individuals, 11/19/13 o Documentation of provider training for one individual, October 2013 o State obstacles report and SSLC addendum, FY13 data, draft, undated o List of each individual and reason(s) (i.e., obstacles) to referral, (none) o Latest post move monitoring form, blank, including helpful hints, October 2013 o PMM tracking sheet, 12/12/13 o Documentation of day of move items (1 individual) o Transition T4 materials for: • Individual #237, Individual #448, Individual #253 o ISPs for: • (none) o ISPA for: • Individual #484 o Pre-ISP draft used during the pre-ISP meeting:

	• (none) o Draft ISP used during the ISP meeting: • (none) o CLDPs for: • Individual #333, Individual #410, Individual #457, Individual #422 o Draft CLDP for: • Individual #406 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 #471: 7, 45, 90 • Individual #390: P, 7, 45, 90 • Individual #356: P, 7, 45, 90 • Individual #355: 7, 45, 90 • Individual #575: P, 7, 45, 90 • Individual #189: P, 7, 45, 90 • Individual #439: P, 7, 45, 90 • Individual #219: 7, 45, 90 • Individual #536: 7, 45, 90 • Individual #127: P, 7, 45, 90 • Individual #383: P, 7, 45 • Individual #113: P, 7, 45 • Individual #570: P, 7, 45 • Individual #422: P, 7, 45, 90 (90-day attended by monitoring team) • Individual #371: P, 7, 45 • Individual #583: P, 7, 45 • Individual #236: P, 7 • Individual #118: P, 7 <u>Interviews and Meetings Held</u>: o Sarah Ham, Interim Admissions and Placement Coordinator, and Cindy Newton, state office o Pamela Gonner, Gail McLain, Placement Coordinators o Group home and day habilitation staff and managers at Daybreak agency, Corsicana, TX <u>Observations Conducted</u>: o CLDP meeting for: • Individual #406 o ISP and/or pre-ISP meetings for: • (none) o ISPA for living options discussion for: • Individual #261, Individual #484

	o Community group home and day program visits for post move monitoring for: • Individual #422
	Facility Self-Assessment The APC self-rated T1c2, T1c3, T1d, T1h, T2a, and T4 to be in substantial compliance. The monitoring team agreed with T1c2, T1c3, T1h, and T4, and also rated T2b to be in substantial compliance. The monitoring team did not agree with the substantial compliance self-ratings for T1d and T2a. This was due, as described in the following report, to a failure to maintain performance in discharge assessments (T1d) and post move monitoring reporting (T2a): this performance was not picked up by the self-assessment. As indicated in previous monitoring reports, the self-assessment's over reliance on the three statewide monitoring tools and failure to include all of the aspects of section T that the monitoring team looks at competed with the validity of the self-assessment and with its correlation with the findings of the monitoring team. Fortunately, shortly after the week of the onsite review, DADS issued a statewide set of new self-assessment tools for section T.
	Summary of Monitor's Assessment Since the last onsite review, there were many changes in the staff of the admissions and placement department. These staffing changes competed with the facility's ability to make much progress in section T. As a result, the facility and DADS proposed reduced monitoring, or no monitoring, for some provisions because they were acknowledged to be in noncompliance before the initiation of this onsite review. Even so, many individuals at MSSLC were placed in the community, referred for placement, and involved in the transition planning process. The number of individuals placed was at an annual rate of about 18%. Approximately 16% of the individuals at the facility were on the active referral list. 29 individuals were placed in the community since the last onsite review. 36 individuals were referred for placement since the last onsite review and 53 individuals were on the active referral list. One individual returned to the facility after community placement; a thorough review of his case had not been conducted. A small sample of CLDPs was reviewed. They were initiated in a timely manner and 3 of the 4 (75%) received ongoing attention during the transition period. Three of the 4 (75%) individuals moved within 180 days of being referred. More work, however, was needed because the CLDPs did not yet identify a comprehensive set of steps the facility would take to ensure a smooth transition (T1c1), or include a comprehensive list of well-described pre and post move supports (T1e). The quality of the discharge assessments declined since the last review and needs to be improved, especially regarding detail on how to provide supports in the individual's new

	home and work settings. Sixty-nine post move monitorings were conducted for 29 individuals. A sample of 45 were reviewed by the monitoring team. They were all conducted within the required timelines and a post move monitoring form was completed. The form, however, did not describe the actions taken by the post move monitor in any detail so that the monitoring team (or any reader) could know what was done to ensure that supports were being provided as specified in the CLDP. Observation of a 90-day post move monitoring demonstrated that it was done thoroughly and correctly.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	Since the last onsite review, there were many changes in the staff of the admissions and placement department, including the departures of many long-term staff: the APC, the PMM, one of the placement coordinators, and the administrative assistant. At this time, the department was staffed by an interim APC, Sarah Ham (she was the PMM until about nine months ago when she changed jobs at MSSLC; she was temporarily appointed to this position), and one experienced placement coordinator, Pam Gonner. The other positions were newly hired or were vacant. These staffing changes competed with the facility's ability to make much progress. As a result, the facility acknowledged noncompliance with most provisions of section T and, for some provisions, proposed that there be reduced monitoring (primarily for CLDP-related activities) or no monitoring (primarily for ISP- and QIDP-related activities, obstacle identification and actions, and quality assurance). The monitoring team notes, in the report to follow, where reduced monitoring or no monitoring was conducted. Even so, many individuals at MSSLC were placed in the community, referred for placement, and involved in the transition planning process. DADS temporarily assigned Cindy Newton, an experienced APC from state office, to work at MSSLC until the time that a new APC is hired and oriented. The number of individuals placed was at an annual rate of about 18%. Approximately 16% of the individuals at the facility were on the active referral list. Below are some specific numbers and monitoring team comments regarding referral and placement numbers and processes. • 29 individuals were placed in the community since the last onsite review. This compared with 33, 28, 17, 25, 23, and 63 individuals who had been placed at the time of the previous monitoring reviews. o The number was similar to that at the time of many of the previous	Noncompliance

		reviews and showed continued referral, transition, and placement activity. • 36 individuals were referred for placement since the last onsite review. This compared with 40, 37, 21, 27, 18, and 44 individuals who were newly referred at the time of the previous reviews. o 2 of these 36 individuals was both referred and placed since the last onsite review. o Clearly, IDTs were continuing to make referrals. • 53 individuals were on the active referral list. This compared with 52, 50, 42, 49, and 73 individuals at the time of the previous reviews. o This showed a stable, and somewhat increasing, trend over the past few years. o 17 of the 53 individuals were referred for more than 180 days. This compared to 28, 14, and 26 at the time of previous reviews. ▪ 10 of the 17 individuals were referred for more than one year. This compared to 2, 3, and 5 at the time of previous reviews. ▪ Based on discussion and based upon notes in the Referral Information document, it seemed that staffing turnover and vacancies in the AP department made it difficult for enough attention to be paid to many of the referrals. • 168 individuals were described as having requested placement, but were not referred. This compared with 107, 85, 157, 160, 168, and 40 individuals at the time of the previous reviews. o Of the 168 individuals who requested placement, but were not referred, 8 individuals had an LAR who made this decision (not applicable). o Of the remaining 160 individuals, a lack of consensus review was conducted for 0. This was noted in the previous monitoring report and should be attended to by the facility. Given the large number at MSSLC, a coordinated effort is likely to be needed. • The list of individuals not being referred solely due to LAR preference contained 68 names. This compared to 100 and 1 individuals at the time of the previous reviews. o This was not an accurate count and should be completed correctly. • The referrals of 12 individuals were rescinded since the last review. This compared to 9, 1, 7, and 20 at the time of the previous reviews. o Documentation (ISPA notes) was provided for 11 of the 11 individuals regarding the reasons for the rescinding. The 12th individual was rescinded right before the onsite review and documentation was not yet available. A special review team was held for 8 of the 11. o 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. This can be done by the APC and APD staff. If done	

		and if actions were recommended, the monitoring team would look for indication of implementation of actions. • 1 individual returned to the facility after community placement. This compared with 2, 0, 1, and 0 individuals at the time of previous reviews. o A review was not conducted, but should be. The individual returned after more than six months of community placement and, therefore, was not considered to be a return from a failed placement, however, the details of the case clearly indicated that a review was warranted. • 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. These data were being obtained for a one-year period after moving. o Of the 60 individuals who moved in the past 12 months, information was provided for 24. It was not known why information was not obtained for the other 36 individuals. Of these 24, 7 were reported to have had one or more untoward events that occurred within the past six months (30% of the 24, 12% of the 60). ▪ It is important for the reader to understand that many individuals who are placed have histories of challenging behavioral, psychiatric, and medical issues. Therefore, it is not unexpected that these issues might occur in the community. o Of these 7, 3 were not resolved and the individuals returned to the facility. No further information was available for the other 4. o All cases should be reviewed 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. ▪ There was a new statewide system and form for reporting these types of events, and for helping the APC to review these events. It was called the Potentially Disrupted Community Transition form. It was not being used at MSSLC. • 0 individuals had died since being placed since the last onsite review. This compared with 1, 4, and 0 for previous reviews. • 8 individuals were discharged under alternate discharge procedures (see T4). The APC had created a number of graphs of the APD's activities. These were good to see and helped to summarize the status and trends of referral, transition, and placement activities. Below are 15 graphs the monitoring team suggests be considered by the APC. The check marks indicate those 10 that the APC had created. • √ 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 • √ 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. <u>Other activities</u> There were no additional referral, transition, or placement related activities at MSSLC, such as work groups. <u>Determinations of professionals</u> This aspect of this provision 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. This was not reviewed by the monitoring team because it was a part of the agreed upon reduced monitoring for section T1a. The facility reported no progress in these ISP- and IDT-related activities.	

		Referrals and Transitions There were no systemic issues delaying referrals (at the facility/local level) identified during this onsite review. Funding availability was not cited as a barrier to individuals moving to the community. Senior management at the facility was not kept informed of the status of referral, transition, and placement statuses of individuals. A presentation to executive committee was done by the placement coordinator each week. This was good to see, but the executive committee was comprised of only a small number of the senior managers at MSSLC. Transitions were not yet occurring at a reasonable pace when considering the full set of placements and referrals over the past six months. 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 the 29 individuals placed since the time of the last onsite review, n.a. (n.a.%) were placed within 180 days of their referral,. o The facility did not have information summarized to make this determination and the monitoring team was unable to find this information within the documents provided. • Of the 53 individuals on the active referral list for community transition, 17 had exceeded the 180-day timeframe (i.e., 68% were within 180 days). o This compared with 28, 14, and 26 individuals who were referred for more than 180 days during previous monitoring reviews. o Of these 17, 10 individuals had exceeded one year. This compared with 2, 3, and 5 individuals at the time of previous reviews. • There were reasonable activity and actions related to the transition and placement, and no long gaps of time with no activity, for 3 of the 4 (75%) individuals whose CLDPs were reviewed in detail (all but Individual #457). • The APC-QIDP report described and commented upon in the previous monitoring report had been discontinued. The APC's staff, however, maintained a document called "Referral Information." It included some comments on the status of some of the referrals. Many noted the challenges due to APD staffing changes and vacancies. • The APC reported that a new weekly meeting of the APD staff was being held. It was primarily to coordinate schedules, but the monitoring team believes it could be used to discuss status of referrals, quality improvements, case reviews, etc. No agenda, minutes, or notes were being kept, but should be.	

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 parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	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.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	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.		
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. The monitoring chose a reduced sample of 4 CLDPs to review. The 4 were based upon recommendations from the APC, Ms. Newton from state office, and the monitoring team. As a result, the 4 CLDPs sampled from the 2 current placement coordinators who were managing CLDPs, the more recent CLDPs, and from across the facility's different units. Initiation: 4 of the 4 (100%) CLDPs were initiated right after the referral. The monitoring team looks for this to occur within 14 calendar days of referral. The MSSLC CLDPs included an initiation date right on the cover page along with the other important dates. This was easy to do and very helpful. Timeliness: 3 of the 4 (75%) CLDPs included documentation to show that that ongoing activity was occurring for the individual's placement. For the fourth, (also past the 180 day date), the CLDP did not indicate what was done each month to indicate that activities were occurring. There were multiple month gaps with no information provided as to what, if any, activity occurred regarding his transition planning. IDT member participation: 4 of the 4 (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). The CLDP for Individual #410 indicated that at the CLDP meeting, problems that occurred during his pre move visit surfaced. These were serious problems related to his behavior with a female staff member. So, fortunately, the IDT and provider were able to respond and find a more appropriate home (all male) within two weeks. On the other hand, it raised questions about why the issue was not addressed prior to the CLDP	Noncompliance

		meeting (see T1e below). Coordination with LA: 4 of the 4 (100%) CLDPs included documentation to show that the facility worked collaboratively with the LA. There was, however, not much activity for the LA to engage in (and not much initiative was taken by the LA), perhaps due to the actions taken by the IDTs, placement coordinators, and transition specialists.	
	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 parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. 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 4 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. Documentation for some training for one individual (name unknown) was provided. It was not clear to the monitoring team if this was an example of what was typically done or if this was the only example. Either way, there was no systematic expectation or assurance that training was done in the manner required below. Only a single pre move support was in each CLDP and within this single support were named the areas in which training was to occur (i.e., PBSP, PNMP, diet, SAPs, meds). This was insufficient and instead needs to include more detail: o (a) who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), o (b) 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 o (c) a competency demonstration component, when appropriate. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). o This was not included in any of the CLDPs. This seemed particularly important given the serious psychiatric, psychological, and behavioral histories of these individuals. • Assessment of settings by SSLC clinicians (e.g., OT/PT, psychology, training and recreation). o This was evident in 0 of the 4 (0%) CLDPs. • Collaboration between provider day and residential staff is ensured. o This was not described in any of the CLDPs, but should be assured by	Noncompliance

		the placement coordinator or transition specialist. • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). o This was not described in any of the CLDPs. <u>Day of move activities</u>: 3 of the 4 CLDPs reviewed (75%) clearly identified a set of activities to occur on the day of the move, and 3 of the 4 (75%) indicated the responsible staff member. There should be some indication, however, that every item on the CLDP day of move list did indeed move with the individual. The APC reported that this was not being done, though the monitoring team received documentation for 1 of the 4 (25%) CLDPs, that is, for Individual #333. It was a one-page document titled Adaptive Equipment Receipt-Move. A more appropriate title might be Day of Move Items Receipt because not all of the items were adaptive equipment, such as medication, belongings, and money. <u>CLDP meeting prior to moving</u>: A CLDP meeting occurred for 4 of the 4 individuals (100%). A CLDP meeting was conducted during the onsite review and was observed by the monitoring team, for Individual #406. Overall, it was a good meeting, with lots of participation. Five of the 7 (71%) of the components of a CLDP meeting were demonstrated at this meeting. 1. Attendance by all relevant IDT members, community providers, and LA 2. Individual preparation occurred prior to the CLDP meeting, if appropriate o The individual responded to questions, but did not appear that he was in any way prepared for the meeting. 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. o At MSSLC, the placement coordinator does all of the post move monitoring, therefore, no other APD staff attended the meeting. The staff might consider doing so (i.e., observing each other) to provide this input, and also to provide constructive feedback for improving the conduct of CLDP meetings. This was done a few years ago and resulted in major improvements in the CLDP meetings at MSSLC.	

		Additional comments about Individual #406's CLDP meeting: • The meeting took two hours. The placement coordinator said her meetings were usually about an hour. In this meeting, an hour was taken up with discussion of ear plugs and dentures. This might have been tabled by the placement coordinator to work out later. Overall, based on the discussion content, this seemed to be a topic that should have been worked out within his IDT prior to this meeting. o Note, however, that there is nothing wrong with a CLDP meeting lasting two hours, as long as the length of the meeting was due to meaningful engaging discussion. This meeting became boring and overly lengthy. • The pre/post move sections of the draft CLDP were blank. The placement coordinator should fill these in as much as she can to give the attendees a set of supports that they can discuss and work from. Typically, some are added, some deleted, and some modified during the meeting. • The placement coordinator should be sensitive to typical problems that occur in pre/post move supports lists, as noted in all of the previous monitoring reports. When these came up during the meeting, there was an opportunity for the placement coordinator to improve the supports: o The psychologist merely proposed to "continue the BSP" and "train staff." The important parts of the BSP should be delineated and the staff training details noted above should also be included. o The DSP described, in good detail, various aspects of how to best interact with Individual #406, including the best ways to wake him up in the morning. This should have become a support. o Work was important to him, but the only support was to "refer to DARS." This is usually inadequate. Fortunately, this provider said they could start employing him at their own offices almost immediately. • During the meeting, Individual #406 said he'd like to participate in cooking and to attend a college class. These should have become supports. • The move date and details of the move came up at the very end of the meeting. This is usually the most exciting part of the CLDP for individuals and, therefore, should occur at the beginning of the meeting. During the onsite review, other CLDP, pre-CLDP, or transition meetings occurred. Two were observed by the monitoring team. Both were ISPAs regarding living options discussion and were initiated by the QIDPs. One was to discuss specific goals for the individual to work towards referral. The QIDP's purpose was to keep the individual motivated to make progress and engaged in the process. For the other individual, discussion was primarily around ensuring successful home visits with his family with the eventual goal of successful community living. Consensus among the IDT members and family was not yet achieved, but the discussion and documentation indicated that thoughtful considerations were occurring.	

	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection because the facility had made limited progress and reported that it was in noncompliance. 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. The following review was based on a sample of assessments from 4 of the CLDPs. For 4 of the 4 CLDPs reviewed (100%), all necessary assessments were completed. For 4 of the 4 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community (there one or two exceptions for one or two individuals). For 4 of the 4 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 4 of the 4 (100%) sets of 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 in 4 of the 4 (100%) sets of assessments. • 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 evident in 0 of the 4 (0%) assessments. The assessor needs to indicate how he or she might see the supports recommended being implemented in the new settings, that is, in the specific home and day	Noncompliance

		program to which the individual was moving. General statements about what the individual needs are appropriate, but the assessments must include commentary on the community settings in which the individual will live, work, etc. Merely including a header called Community Living is not sufficient. During previous monitoring reviews, MSSLC had done a better job of doing so in their discharge assessments than found during this review. • 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 This was evident in 0 of the 4 (0%) assessments. The comments immediately above apply to this bullet, too. The CLDPs continued to contain a description of the deliberations of the IDT during the CLDP, as well as the recommendations finalized during the deliberations. The descriptions, however, were more of a cut and paste from the assessment than a description of the deliberations. During previous monitoring reviews, the deliberations were described in better detail. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The discharge assessments must better address the specific home, day, and employment sites and contexts into which each individual will be moving.	
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-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	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. The lists of pre-move and post-move supports were identified in the CLDPs. MSSLC had made some progress in creating comprehensive lists for each individual, primarily around personal preferences. 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 0 of the 4 (0%) CLDPs. Supports that required implementation of PBSP were insufficient because they did not include the important aspects of the plans, such as teaching replacement behaviors and engaging in ways to prevent the problem from occurring. Many of the individuals had complex psychiatric diagnoses, previous failed community	Noncompliance

	departure from the Facility.	placements, and serious behavior disorders. For example, • Individual #410 had a lengthy history of sexual and physical abuse, including two serious peer to peer in the month prior to his CLDP meeting and exhibition of inappropriate sexual remarks and actions while on the pre move visit with the provider within the previous month. This was not addressed in the CLDP other than to continue the BSP. There was nothing about implementing the communication strategies described in his CLDP assessments. • Individual #333 had a list of serious diagnoses, disorders, and symptoms, including psychoses, anxiety, auditory command hallucinations, and violence. This was not addressed. • Individual #333's CLDP indicated recent schizophrenia symptoms, and the requirement for substance abuse treatment. His recent psychiatric problems led to his IDT slowing his transition, but only by a month. The importance of attending to his psychiatric needs and substance abuse treatment were not adequately addressed in the CLDP. o All safety, medical, healthcare, risk, and supervision needs addressed. ▪ This was demonstrated in 2 of the 4 (50%) CLDPs. ▪ Overall, IHCPs could have been better transformed into useful information for the pre/post move support lists. ▪ For Individual #410, the CLDP did not adequately address his smoking, insomnia, hemorrhoids, constipation, and TD. o What was important to the individual was captured in the list. ▪ This was evident in 4 of the 4 (100%) CLDPs. For example, the list included cooking and meal preparation for Individual #410. o The list thoroughly addressed the individual's need/desire for employment. ▪ This applied to 3 of the 4 CLDPs. The supports listed related to employment were adequate for 0 of the 3 (0%). Merely stating, refer to DARS or work to earn money were insufficient and likely not result in adequate employment opportunities. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included. ▪ This was included in 1 of the 4 CLDPs (25%), that is, for Individual #457. Having a support that merely says "continue to implement the BSP" was insufficient. Moreover, in some of the CLDP narratives, the importance of positive reinforcement	

		was noted (e.g., Individual #333). 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 4 (25%) CLDPs. This should be improved. Individual #333's were only at day program, Individual #457 only had one skill, and Individual #422 had none. o There were supports for the provider's implementation of supports. That is, the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. ▪ 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 4 (0%) CLDPs. Examples of what should have been included were the interactional and positive reward components of PBSPs and the most important details of the PNMPs, dining plans, and nursing care plans. o Topics included in training had a corresponding support for implementation. ▪ This was evident in of 0 of the 4 (0%) CLDPs. • The wording of every support is in appropriate, measurable, and observable terms. o Supports regarding appointments were written adequately and the supports for many outings included the number of times per week or month. The provider and PMM must know 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 The CLDPs included a paragraph or two describing the deliberations and discussion by the IDT for each area of service and support. This should continue and also should include the rationale for any recommendation in the assessment that was determined to not be necessary to include in the final list of recommendations. The descriptions of deliberations were not as thorough as found during previous reviews. • 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 Evidence that the PMM should look for was included in all of the CLDPs (100%), however, improvements were needed. ▪ As discussed during the onsite review, the APD staff should consider three types of evidence for many of the supports: documentation, observation of implementation, and interview of staff. Doing these three activities is a very good way to be confident that the support was being provided. To help with this, the monitoring team again recommends that a checklist or check sheet be created. ▪ The supports, however, were missing any criteria to give guidance to the PMM. That is, many merely said "observation notes." To improve, the monitoring team recommends that the APC create a self-assessment for the pre- and post-move support section of the CLDP. She can use the above items to create this checklist for herself and her staff. This has been recommended in many monitoring team reports. 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 4 of the 4 in the sample (100%). ▪ 4 of the 4 (100%) indicated that the pre-move supports were in place. o The APC staff should provide detail indicating if all of the aspects detailed in the CLDP regarding training occurred as per the CLDP, such as who, what, how, and documentation of competency. • Each of the nonessential/post-move supports needs to have an implementation date. o 4 of the 4 (100%) CLDPs included specific due dates for each support. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. At this point, the APC and transition specialists should be able to meet all of the criteria for a thorough and adequate list of pre- and post-move supports. Following the above comments regarding the 8 components of a comprehensive list, and the 3 additional characteristics will move the facility towards substantial compliance.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

	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.		
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.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 6/1/13 through 12/6/13. 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. The facility will need to include this list in order to maintain substantial compliance.	Substantial Compliance

	ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
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,	MSSLC did not maintain substantial compliance with this provision item. This was due primarily to the change, for most of the previous six months, to a revised post move monitoring report form that did not provide adequate information (see below). In the past month or so, the facility began using a report form that contained more adequate information. Since the last review, 69 post move monitorings for 29 individuals were completed (4 post move monitorings for 2 individuals were completed by Lubbock SSLC staff). This compared to 87 post move monitorings for 38 individuals, 55 post move monitorings for 27 individuals, and 38 post move monitorings for 16 individuals at the time of the last reviews. The monitoring team reviewed completed documentation for 45 (65%) post move monitorings for 18 different individuals. Of the 45 post move monitorings, 19 were completed by the experienced placement coordinator Pam Gonner, 17 by the transition specialist Kellen Davis, 8 by the new placement coordinator Gail McLain, and 1	Noncompliance

	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.	by the previous post move monitor Jeannette Reaves. Timeliness of Visits: For the 29 individuals, 69 reviews should have been completed since the previous review. Based upon a chart presented to the monitoring team and by the post move monitoring reports, of the 69 required visits, 69 (100%) were conducted and 69 (100%) were completed on time. Of the 45 post move monitoring forms reviewed by the monitoring team, all 45 (100%) included dates showing that they were completed on time. Locations visited: For the 45 post move monitorings reviewed, 2 (4%) clearly indicated that the PMM visited the locations at which the individual lived and worked/day activity (e.g., day program, employment; no individuals attended public school) were visited. These were the two new style forms. The other forms did not indicate if the PMM visited the home, day, work, and/or school sites. Content of Review Tool: 45 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. The post move monitoring form had gone through a number of changes since the baseline monitoring review in 2010. Of these 45 forms, 43 were completed on the form used through November 2013. 2 were done on the newest iteration of the form, which began to be used for new post move monitorings in November 2013. The newest iteration was designed to address the concerns raised by the monitoring team regarding the May 2013 form. The monitoring team is not yet able to comment on whether the newest iteration of the form will be sufficient to meet substantial compliance because, in this sample, only 2 forms were used. Both were for 7-day reviews, which made it impossible to determine if thorough reporting would be done, if it would be completed cumulatively, and if adequate detail and description would be included. In these two examples, more detail was certainly needed, including an overall statement of the placement. For many of the supports, the evidence reviewed column merely stated that the support was in place rather than what was reviewed. For Individual #118, the evidence for many of his supports was his self-report. Instead, there should also be staff interview and documentation. His staff training support, for instance, noted that the PMM looked at inservice documentation and conducted staff interviews. Further, most of the supports for these two individuals were not to be reviewed until the 45-day visit.	

		The post move monitoring report forms were completed correctly and thoroughly, as follows: • The checklist was completed in a cumulative (or somewhat cumulative) format across successive visits for 11 of the 27 (41%) 45- and 90-day visits. • Supports were verified, such as by indication of the evidence examined and the results of this examination, in 4 of the 45 (9%). o The PMM should provide detail in her report regarding whether she had evidence of all aspects of required training, such as who, what, how, and documentation of competency. o The PMM should provide a description of the evidence examined: documentation, observation, and/or interview. • Detail/comment was included in 14 of the 45 (97%) reports for most every support. The reports did not contain thorough detail about the status of each support. • LAR/family satisfaction with the placement and the individual's satisfaction were explicitly stated in 34 of 45 (76%). • 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 10 of the 45 (22%). For these 10, the PMM (Ms. Gonner) included a statement within the item regarding individual and LAR opinion of the placement. <u>General status of individuals</u> Based upon the monitoring team's review of documents and discussion with the APC and PMM, of the 18 individuals who received post move monitoring, 18 (100%) transitioned very well and appeared to be having good lives. 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 17 of the 48 post move monitorings (34%), additional follow-up, assertive action, and activities were required of the post move monitor. These were for 10 of the 18 individuals (56%). Most of the problems were of a moderate level, such as delays in medical appointments, obtaining of Medicaid cards, or items not having moved with the individual from the facility. There was appropriate follow-up and correction for 15 of these 17 (88%). Ms. Gonner regularly brought all concerns to the IDT and held an ISPA meeting. The two that did not receive follow-up were not on her caseload. One was for Individual #439. At his 45-day, he had received new psychotropic medications and been to the emergency room for staple/sutures due to a fall. At Individual #113's 45-day, he had stolen some items from a local store and was also late on some appointments. There	

		should have been some review and follow-up following both of these post move monitorings. <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 14 out of 17 (82%) of post move monitorings for which an ISPA was appropriate to have been held.	
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 #422 for the 90-day review. The PMM, Pam Gonner, did a thorough and complete job post move monitoring. This was based on observation of the PMM's: • Examination and verification of every 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. The day habilitation and community home were visited. Both sites were pleasant, clean, and neatly furnished. The staff were very knowledgeable about the individual. Overall, this appeared to be a good placement for the individual. Some examples of the positive activities taken by the PMM: • Ensured that she saw the actual appointment form completed by the eye doctor rather than only accepting an observation note entry that it was completed. • Checked the individual's shoes to see if she was wearing insoles (she was) and if staff could talk knowledgeably about the insoles (they did). • Looked to see if the adaptive mealtime equipment appeared to be regularly used based on storage and labeling. • Asked the program director about attempted contacts with family members. • Reviewed the day and home observation notes to see how/if they kept regular data on SAPs. She discovered a problem in the data collection system (regarding how prompting was recorded). To continue to improve: • The post move monitoring report should provide detail on what exactly she	Substantial Compliance

		looked at; the report did not reflect the detailed post move monitoring activities that she engaged in (i.e., it under reported the depth and breadth of the post move monitoring). • When possible, try to interview the staff member in a quiet spot where she is not engaged in other activities at the same time. Also, do some questioning and interviewing with each of the staff members present. • Help IDTs to develop pre/post move support lists that include adequate detail and required evidence, so that she can better monitor, such as o Developing checklists to document implementation of many different types of supports (e.g., parts of the PBSP and PNMP, in home leisure activities, preferred foods). o Specifying what is required when a pre/post move support refers to a training objective.	
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:	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. Eight individuals were listed as being discharged as per section T4. Thus, their discharges were required to meet this provision's discharge and transfer requirements. A sample of 3 individuals was reviewed. Two were transferred to another SSLC; the third	Substantial Compliance

	(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	was transferred to a state mental health facility directly from jail based on a court order. <u>Compliance with CMS-required Discharge Planning Procedures</u>: Based on a review of the discharge summary completed for the individuals listed above under Documents Reviewed, 3 out of 3 (100%) did contain the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. These include a summary of the individual's developmental, behavioral, social, health, and nutritional statuses. A review was conducted to determine whether or not the facility met the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process is discussed below: • In 3 out of 3 records reviewed (100%), good cause was identified in the discharge summaries. • The facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies) for 3 out of 3 individuals (100%), reasonable time was given to prepare. • The facility developed a final summary of the individual's developmental, behavioral, social, health and nutritional status, and the information was adequate for 3 out of 3 individuals (100%). • For 3 out of 3 individuals (100%), the facility provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving facility. • Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the report for 3 out of 3 individuals (100%) adequately described the key supports that the individual would need in the new setting.	

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o MSSLC Rights Assessment form o Prioritized Need for Guardianship List o MSSLC Self-Assessment and Provision Action Information for section U o MSSLC Section U Presentation Book o MSSLC Section U Monitoring Tool o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans: • Individual #300, Individual #130, Individual #927, Individual #231, Individual #951, Individual #139, Individual #589, and Individual #225 o Draft ISPs and Assessments for Individual #105 and Individual #160 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, psychologists, and QIDPs in homes and day programs o Joy Lovelace, Human Rights Officer o Ramona Echols, Acting QIDP Director o Carla Wilkins, QIDP Educator o Melinda High, ISP Facilitator o Laura Gore, ISP Facilitator Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 12/9/13 o Annual IDT Meeting for Individual #105 and Individual #160 o Pre-ISP Meeting for Individual #505
	Facility Self-Assessment: MSSLC submitted its self-assessment, updated on 11/25/13. 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 and U2 included: • Reviewed a sample of 22 ISPs from 4/1/13 through 9/30/13 for discussion regarding ability to give consent.

	• Reviewed the facility's prioritized list of individuals determined to need guardians or advocates. The facility self-rated U1 and U2 in noncompliance. Findings from the facility self-assessment were similar to findings of the monitoring team for section U. The monitoring team agreed with the facility's noncompliance ratings for U1 and U2 and commends the facility for continuing to assess progress through the self-assessment process.
	Summary of Monitor's Assessment: The facility continued to maintain a list of individuals determined by the IDT to need a guardian or advocate. The list was updated on 11/14/13. Each individual on the list was assigned a priority rating of 1 through 6. Individuals considered a Priority 6 were deemed those in greatest need of a guardian or advocate. This list included seven individuals considered a Priority 6 for guardianship and 26 individuals considered a Priority 5 for guardianship. Seventy-three other individuals on the list were rated as a Priority 3, Priority 4, Priority 5, or Priority 6 for an advocate. Guardianship had not been obtained for any of the individuals deemed a priority in the past six months. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. Progress had not been made towards compliance with this provision. 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 not reviewed during this round of monitoring visits. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with provision U1 as a prerequisite.

#	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	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. The facility continued to use the Determination of Need for a Guardian or Advocate Tool to assess each individual's need for guardianship. Additionally, the Rights Assessment, Functional Skills Assessment, and Physician Annual Medical Assessment were used to determine each individual's capacity to give informed consent. IDTs were responsible for reviewing assessment information and determining if a referral for guardianship was appropriate. It will be important for QIDPs to document recommendations from the assessment process and ensure that outcomes are developed to address any barriers to each individual's ability to make decisions when deemed applicable.	Noncompliance

#	Provision	Assessment of Status	Compliance
	express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The HRC reviewed all rights assessments submitted by the IDT. Assessments were routinely returned to the IDT for additional information/clarification when incomplete or justification for restrictions was deemed inadequate. Two annual ISP meetings were observed, for Individual #105 and Individual #160. Both individuals had guardians. Neither IDT held an adequate discussion regarding each individual's ability to make informed decisions or considered developing training opportunities to improve decision making skills, even at the most basic level (e.g., simple choice making). A sample of ISPs was reviewed to determine if IDTs were adequately addressing each individual's ability to give informed consent. It was not yet evident that an adequate discussion was routinely taking place at annual ISP meetings. The facility self-assessment findings were similar to findings by the monitoring team. Information presented at the section U monthly PET meeting for September 2013 indicated that none of the ISPs reviewed in the sample included adequate discussion of the individual's capacity to give informed consent. Examples of ISPs that did not include adequate discussion regarding individual's ability to make decisions and provide informed consent: • Individual #300 was an adult with no guardian. The IDT determined that he did not need a guardian because his family was involved and advocated on his behalf. Family members did not attend his annual IDT meeting. The team, however, determined that he was not able to provide consent for medical or financial decisions. His rights assessment indicated that he would have restrictions on his money due to his "lack of monetary skills to understand the value of money, make coin combinations, make purchases, and budget money." His ISP stated that he was independent in a majority of his money management skills, however, he needed assistance in opening and maintaining a savings or check account. • Individual #121 was an adult with no guardian. The ISP noted that his family no longer wished to be his primary correspondent. It was determined that he could not give informed consent in most areas. The IDT agreed to refer him for an advocate. Discussion regarding his decision making skills, possible training opportunities related to decision making, or the need for a guardian versus an advocate was not documented. • Individual #518 was an adult with no guardian. Her IDT acknowledged that she did not have the skills necessary to provide informed consent. They did not document discussion regarding her decision making abilities, even regarding	

#	Provision	Assessment of Status	Compliance
		basic choices that she may make daily. Her ISP indicated that her brother acted as an active advocate for her and was involved in all decision making. She had significant medical problems and restrictions to her rights. She was not referred to the community due to her medical condition and need for 24 hour nursing and one-to-one supervision. The team did not discuss her need for a legal guardian to make decisions on her behalf. To move forward, the facility will need to: 1. Ensure an adequate assessment process is used to determine each individual's need for guardianship. 2. Ensure that the facility's priority list for guardianship is accurate based on information gathered at annual IDT meetings.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

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, November 2013 o MSSLC policy lists, October 2013 o List of typical meetings that occurred at MSSLC, undated but likely November 2013 o MSSLC Self-Assessment, 11/25/13 o MSSLC Action Plans, 11/25/13 o MSSLC Provision Action Information, 11/20/13 o MSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 12/9/13 o List of all staff responsible for management of unified records o Description of changes since the last onsite review (there weren't any changes) o List of other binders or books used by staff to record data (food intake, BMs, SAPs) o Description of the MSSLC shared drive o Tables of contents for the active records, individual notebooks, and master records, no changes o Birth certificate and social security card action reports, and facility wide new data base o Annual retraining schedule showing "Documentation" topic, and six months of statewide data base reporting the percentage of staff who were up to date on their annual refresher training o Active record checkout audit, June 2013 to August 2013 o Individual notebook monitoring form, done by ATCs, 2 examples, July 2013 and September 2013 o Blank pre-ISP meeting PSI assessments needed form o SAPs to be implemented form, completed at ISP, one example, November 2013 o List of all state and facility policies, 11/18/13 o List of all state and facility policies and staff training-related information, 11/18/13 o Another list of facility policies, those new 4/25/13 and staff training information, 11/18/13 o QAQI Council policy review notes, 9/26/13 o Graph of staff training on eight policies, 10/31/13 o Description of the unified record audit process o Blank tools used by the URC (table of contents tool and statewide tool), no changes o List of individuals whose unified record was audited by the URC, June 2013 to November 2013 (five per month) o Completed audits for 10 individuals, September 2013 and October 2013 • Active record and individual notebook • Master record • Statewide self-monitoring tool

	• Additional notes/comments for each audit o Interobserver agreement information for September 2013 and October 2013 and minutes from two meetings with QA department about interobserver agreement, September 2013 o Emails to department heads regarding corrections needed and/or problems identified as a result of the unified record audits o Audit tracker, May 2013 through August 2013, showing follow-ups through November 2013 o Description of status of September 2013 audit tracker (not due yet) o A table showing if corrections were completed o Documentation error totals, June 2013 through November 2013, graphed by type of documentation error (7), and graphed by residential unit (5) o Delinquent/missing documents totals, May 2013 through October 2013, and also by department o Email from Nursing Operations Officer regarding zero delinquent documents by nursing department, 9/27/13 o Graph of active record checkouts done correctly, June 2013 to August 2013 o Graph of individual notebook monitoring, April 2013 to September 2013 o QA report for section V, August 2013 and November 2013 o Description of how MSSLC addressed all six components of section V4 (none) o Active records and/or individual notebooks of: • Individual #182, Individual #631, Individual #569, Individual #571, Individual #1, Individual #505, Individual #45, Individual #393, Individual #657, Individual #342, Individual #802 o Master records of: • Individual #839, Individual #300, Individual #197 <u>Interviews and Meetings Held</u>: o Sherrie Price and Debbi Reichert, Unified Records Coordinators o Elaine Schulte, Director of Client Records (absent) o DSP staff across MSSLC campus <u>Observations Conducted</u>: o Records storage areas in residences o Overflow and master records storage area o Nursing administration meeting
	Facility Self-Assessment The self-assessment for V1 correctly used data from the V3 quality assurance audits to help make the self-rating of substantial compliance for V1. The self-assessment would be better, however, if, in addition, it contained all of the sections and items that the monitoring team includes in the monitoring report. The self-assessment for V2 would benefit by separating out the state and facility policies for each of the provisions of the Settlement Agreement from the other policies that are MSSLC-specific. Further, the self-

	assessment should include a report of the different areas (columns) on Ms. Thompson's spreadsheets. For V3, the self-assessment should focus on the implementation of the quality assurance audit process, including were five done per month, was there IOA, were responsible staff notified, were corrections made, was trending done, was analysis completed, were actions developed and implemented, etc. The V4 self-assessment should report on all six of the areas that the monitoring team assesses for V4. The facility self-rated itself as being in substantial compliance with V1, and in noncompliance with V2, V3, and V4. The monitoring team agreed with these self-ratings.
	Summary of Monitor's Assessment: MSSLC maintained substantial compliance with provision V1. Progress was seen in provisions V2 and V3, but not in V4. All 100% of the 1,500 staff were up to date on their annual recordkeeping refresher training. Eleven of 11 (100%) individuals' records reviewed included an active record, individual notebook, and master record. For each record, more than 90% of required documents were present, current, and substantially in compliance with the requirements of appendix D. The monitoring team's review of active records showed approximately 6 errors/missing documents per active record. Individual notebooks continued to be used for all individuals and as per state policies. Staff interviewed by the monitoring team appeared comfortable with, and knowledgeable of, the individual notebooks. Active treatment coordinators conducted monthly reviews of content and quality of every individual notebook. A master record existed for every individual. Overall, the master records were in good shape. MSSLC recently initiated a project to ensure each individual had a birth certificate and social security card in his or her master record. Not all state policies were in place yet, though continued progress was evident (only provisions G and H did not have a state policy). MSSLC had three spreadsheets to address this provision. 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. As noted in previous reports, it was now past the time that the tools used for these audits be updated and made more valid, as has been done at many of the other facilities. For the table of contents reviews, the URCs found, on average, about 7 errors regarding missing documents, and about another 3 regarding documentation/entry problems, such as poor legibility or missing signatures. The URC notified the relevant facility staff regarding these needed corrections. Then, she followed-up to

	determine whether corrections were completed. 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. Analysis and resultant action are required for substantial compliance to be obtained for section V3. The URCs reported that V4 was not a focus of the recordkeeping department in the last six months. Thus, no work was done to address the requirements of this provision and the facility was in substantial compliance with none of the six items.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	The recordkeeping department at MSSLC maintained substantial compliance with this provision. Progress was seen in provisions V2 and V3, but not in V4. The recordkeeping department remained under the direction of Elaine Schulte, the director of client records (DCR). She was not available during this onsite review; the monitoring team looks forward to seeing her at the next review. Sherrie Price continued as URC and, since the last review, one of the record clerks, Debbi Reichert, was appointed as the second URC. The URCs took most of the lead in the management of recordkeeping activities and initiatives related to provisions V1, V2, and V4. Patty Thompson remained the lead for section V2. Home record clerks continued to oversee the active records, active treatment coordinators and unit administration oversaw the individual notebooks, and the DCR and URCs oversaw the master records. After years of relative stability, there was considerable turnover in the five record clerk positions. At the current time, there was one vacancy and four of the other five were new to their positions. As a result, the active record audits that were being conducted by the record clerks were not yet re-instated. The DCR should consider re-instating these once new clerks are hired, trained, and settled into their new positions. State policy and facility policies remained the same since the last review. The table of contents and guidelines for the three components of the unified record remained the same, too. Specific actions were initiated, or continued, regarding each of the three components of the unified record. They are described below. Regarding the entire unified record, recordkeeping activities were part of new employee orientation and recordkeeping	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		practices were included in the annual retraining of all staff. The URCs provided training statewide database information showing that 100% of the 1,500 staff were up to date on their annual recordkeeping refresher training. Eleven of 11 (100%) individuals' records reviewed included an active record, individual notebook, and master record. <u>Active records</u> The status of the active records maintained since the last review. The monitoring team reviewed active records in each of the five units at MSSLC. 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 monitoring team's review of active records showed approximately 6 errors/missing documents per active record. There were similarities in the documents that were missing across the active records that were reviewed by the monitoring team. The URCs might explore this further. They were Code Status/Advance Directives, Trust fund consent, dental/medical treatment consents, Self-administration medication skills assessment, colonoscopy reports, and diet orders. Further, many IPN pages had gaps at the bottom. A simple line should be drawn across these empty lines. Some procedures were put into place to make it more likely that the active records would continue to improve and that progress obtained over the past few years would be maintained. These were: • Continuation of audits, feedback, and follow-up, as per section V3. • The pre-ISP meeting's list of required assessments (from the PSI document), was given to the record clerk, so that she would know what assessments she needed to look for and monitor. • Following the ISP meeting, the QIDP prepared a list of SAPs that needed to be developed, so that the record clerk would know what SAPs she needed to look for and monitor. • Each home had a binder called the Checkout Book in which staff were supposed to sign the active record out and back in, so that an active record could be located if it was missing from the active record shelf. For three months, June 2013 to August 2013, the URCs did a check of the Checkout Book. It was stopped, however, due to staff turnover. The monitoring team and the URCs discussed a more valid way of assessing this, that is, to have record clerks do a	

#	Provision	Assessment of Status	Compliance
		periodic (e.g., daily) check of all of their active records and, for any that were missing, see if they were checked out correctly. This activity, in addition to improving the status of the active records, could also help satisfy provision V4, item 1. <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 individual notebooks contained the ISP and the IRRF, but not the IHCP. Staff interviewed by the monitoring team appeared comfortable with, and knowledgeable of, the individual notebooks. For instance, Victoria Johnson, DSPI, thoroughly described Individual #45's individual notebook. Cedric Davis, DSPII, showed each page of the individual notebook and where data were recorded. April Ballou, DSPII, showed the monitoring team how SAP data were recorded and maintained (in a separate binder). Homes had some variations on how they managed the individual notebooks, all of which were reasonable, as long as data are up to date and documents do not get lost. For example, one home had all of the individual notebooks opened to the PBSP data pages to make it easy for staff to record data. In another home, the observation notes were pulled out of the individual notebooks, so that staff could more easily make entries. Staff said that the observation notes were filed into the active record at the end of every day. The system of having active treatment coordinators conduct monthly maintenance review of the content and quality of every individual notebook continued. They completed an Individual Notebook monitoring form for each. The monitoring team reviewed a small sample. Data from these forms were summarized and graphed each month and submitted to the URCs. The monitoring team looked at a sample of these data sheets and found them to be up to date. <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. In some homes, SAP data sheets were kept in a separate binder; these were to be managed by the education and training department/master teachers.	

#	Provision	Assessment of Status	Compliance
		<u>Master records</u> A master record existed for every individual at MSSLC. Overall, the master records were in good shape. Since the last review, the DCR and URCs initiated a project to ensure each individual had a birth certificate and social security card in his or her master record. To that end, a check sheet was created for new admissions, and an assessment was done of every active record. There was, however, no report regarding what the recordkeeping department was doing to obtain missing birth certificates and social security cards. This should be included in the recordkeeping department's activities. For many reviews now, the monitoring team has recommended that the DCR: • Mark up the master record table of contents to indicate what is/is not in the record (so that anyone reviewing the master record would easily know the contents). • After engaging in activities to obtain any missing document, but failing to obtain it, put in a note to indicate what was done so that future explorers of the master record will not unnecessarily repeat any of the same search tasks. <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 three spreadsheets to address this provision. Moreover, a graphic summary was made of one of these three. These were continued nice improvements. They were developed and managed by Patty Thompson. Not all state policies were in place yet, though continued progress was evident (only provisions G and H did not have a state policy). One of three 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. Moreover, it appeared that many of the state policies were not adapted (localized was the term used at the facility) for MSSLC. The spreadsheet was designed to capture this information. 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. It 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. As recommended in the previous report, Ms. Thompson now included an "as of" date for each policy, so that the reader knows that the training data were 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. The third spreadsheet listed a set of facility-specific policies that were not part of the set of state-issued policies (e.g., ethics committee, intra-facility transfers). This spreadsheet tracked the policy's approval and implementation dates, the number of staff required to have completed training, the number that did so, and an "as of" date. Further, the data were converted to percentages and graphed for eight of the policies. All of this was very good to see. The monitoring team sees no reason why the facility could not achieve substantial compliance with provision V2 in the near future. All that is needed is completion of the first two spreadsheets, all staff trained as needed, state completion of policies for G and H, and a description of the third spreadsheet, so that the reader understands whether this lists all of the facility specific policies or only some of them.	
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	Five reviews (audits) were conducted in each of the previous six months. All of the reviews were done in a fairly consistent manner, were reported to take about two hours to complete, and were neatly and clearly documented. The review consisted of four parts: • Active record and individual notebook • Master record • Statewide self-monitoring tool • Additional notes/comments for each audit	Noncompliance

#	Provision	Assessment of Status	Compliance
	procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	The database of medical consultations continued to be used to assist the URCs in conducting these reviews. They looked back at the last three months of consultation per individual. A longer period, such as up to a year, is more appropriate. They used the ISP and the QIDP-generated list of SAPs to help them determine what SAPs should be in the active record. To control for potential unintentional observer drift or bias, interobserver agreement was now being obtained for both the statewide tool and the table of contents tool. The URCs worked closely with the QA department's program monitor to improve IOA scores. Two meetings were held in September 2013. IOA data for September 2013 and October 2013 were reported to show 100% agreement. This calculation, however, was only for the statewide tool. A calculation should also be done for the table of contents tool. As long as IOA scores for both tools remain high, the monitoring team suggests that IOA only need be assessed for one of the five audits each month. The URCs' plan to have the IOA occur immediately after their own review made sense. As noted in previous reports, it was now past the time that the tools used for these audits be updated and made more valid, as has been done at many of the other facilities. In particular, the combination of the statewide tool and the TOC tool should occur. 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 the URCs to assess V4. For the table of contents reviews, the URCs found, on average, about 7 errors regarding missing documents, and about another 3 regarding documentation/entry problems, such as poor legibility or missing signatures. Items needing correction were counted separately (one set of data were called documentation errors, the second set were called delinquency errors, i.e., missing or incorrect documents). It was good to see this separation, however, the data should also be combined into a total number of errors. 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. After completing these two parts of the review, the URC made a list of all things that needed correction in all three parts of unified record and she added comments as needed. Then, the same system continued that had been in place for a number of onsite reviews:	

#	Provision	Assessment of Status	Compliance
		The URC notified the relevant facility staff regarding these needed corrections. Emails to facility staff regarding corrections and requesting follow-up were done in a pleasant and professional tone. Color-coding was recently implemented to make it easy each discipline department to identify the corrections that they were responsible for correcting. Then, she followed-up to determine whether corrections were completed. Follow-up was taken seriously by the nursing department, as evidenced by their attention to the list of delinquent/missing documents, as evidenced in a 9/27/13 email from the nursing operations officer to her staff and to the CNE noting that there were zero delinquent/missing nursing documents across campus. 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, the total number corrected out of the total possible was given at the bottom of each column. The audit tracker had been discontinued at the time of the last review, but was implemented for the entirety of this six-month period. The URCs had a set of graphs. There were some improvements since the last review. Below is a list that the URCs can use to develop a full set of graphs and some comments regarding the status of current graphs. • Average score on statewide self-assessment tool portion of the audit. o This should generate one data point per month. This was not being done. • Total number of corrections need for all five reviews. o This should be the total of both the documentation errors and delinquency items. The total can be easily taken from the comments page (or the last page of the statewide tool). • Documentation errors data (this is a subset of the total number in the above closed bullet) o Data were being graphed facility wide by type of error, and by residential unit. No changes needed here, continue doing this in the same manner. • Delinquency ("D-list) data (this is the second subset of the total number in the above closed bullet) o This was not being done for the five monthly audits, but should be. o This was being counted for the entire facility. The monitoring team, however, could not determine how these numbers were determined, such as whether the totals were for every individual at the facility or a sample. Further, this set of facility data might only have been for ISP	

#	Provision	Assessment of Status	Compliance
		assessments being handed in no less than 10 days prior to an ISP meeting, not for all of the documents that are included in the D-list when the URCs conduct their monthly audits. The self-assessment, however, contained information indicating that a wide variety of documents were included in this determination. • Percentage of items that were corrected within the specified two-month time period. o This was being done, no changes needed. • A data set and graphs for the V4 activities. o This was not being done. • The URCs were graphing two other sets of data, which was great to see: o Active record check out procedures (though discontinued in August 2013) o Individual notebook monitoring The URCs were including the data graphs in their quarterly QAQI Council presentations and PET presentations. A more complete set of data would be of more interest to those groups. 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. Analysis and resultant action are required for substantial compliance to be obtained for section V3.	
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 URCs reported that V4 was not a focus of the recordkeeping department in the last six months. Thus, no work was done to address the requirements of this provision. During the onsite review, the monitoring team reviewed V4 with the URC, including sharing some suggestions for how to address V4 by the time of the next onsite review. The facility was in substantial compliance with none of the six items (0%). Below, the six areas of this provision item are presented, with some comments regarding MSSLC's status on each.	Noncompliance

#	Provision	Assessment of Status	Compliance
		1. Records are accessible to staff, clinicians, and others The MSSLC active record checkout books and audits of the presence of active records could be used to in part satisfy this part of V4. The monitoring team observed that: • 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 10 (83%) of 12 individual notebooks in the sample. IHCPs, however, were not available to staff in 7 of the 12 records. • When the monitoring team requested the individual's active record, and the individual's All About Me book (individual notebook), both were readily located by the staff. • In general, individual notebooks were generally accessible to DSPs. • The active records were available to the clinicians (OT, PT, SLP, and the PNMT), as evidenced by most of the IPN entries being handwritten and completed at the time of the contact. • When asked why the individual records were not available for the PNMT meeting, the clinicians indicated that they did not want to take them off of the living areas, which would restrict access for others. 2. Data are filed in the record timely and accurately For this item (#2), the monitoring team looks to see if the documents in the active record are up to date. This differs from the item immediately below (#3) for which the monitoring team looks to see if current data sheets are being completed expediently and correctly (e.g., behavior data sheets, seizure logs, PNMP logs). MSSLC was somewhat assessing this during the monthly audits, that is, when the URC indicated whether a document was in the record, up to date, and in the right place. The information from these reviews, however, should be used to satisfy this requirement, too. The monitoring team observed that: • Current information was filed and in chronological order. • Some data presented to the psychiatrist during this monitoring visit were old. 3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure) The monitoring team observed that: • Of the active records reviewed with a seizure record, the data were documented and recorded timely. • There were minimal recorded entries for late documentation.	

#	Provision	Assessment of Status	Compliance
		• Unfortunately, only 64% of PBSP data sheets reviewed had data recorded in a timely fashion. • Data for direct habilitation therapy was generally reported as treatment notes. Monthly reviews were consistently completed in a timely manner and contained a report of actual clinical data as it related to established objectives of intervention with appropriate analysis. • QIDP monthly reviews indicated that data on progress towards ISP outcomes was often unavailable at the time of review. <u>4. IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> The monitoring team observed that • A number of records included initial and follow-up assessments, which did not include use of the active record. For example, the active record for Individual #160 was not used to review earlier episodes of vomiting for any trends or patterns. • There was clear review of the active record in the PNMT, OT/PT, and SLP assessments. <u>5. Staff surveyed/asked indicate how the unified record is used as per this provision item</u> The monitoring team found • Staff were not interviewed. The "V4 interviews" were discontinued at MSSLC. • During opportune times during residential rounds conducted by the monitoring team, questions were posed to a number of nurses as to how the individual's record health information was used to make decisions about care and services. o For the most part, the verbal responses were consistent, and some were more detailed. For example, the RN Nurse Manager used an example of a head injury. She provided a detailed report of what records she reviewed, such as historical information and recent routine consults. o However, a number of records relied on the chief complaint, and there was inconsistency for including recent or historical information. For example, administration of pain medication often solely relied on the medication record. • Psychiatry clinic staff were noted to utilize other information with regard to making treatment decisions (e.g., psychology evaluations, data graphs, MOSES, DISCUS, nursing information, and other clinical data). <u>6. Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item, and data are reported rather than only clinical impressions</u> The intent of this item is for the record to be present and available, and that it is used	

#	Provision	Assessment of Status	Compliance
		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 QIDP provided IDT members with a draft ISP and IHCP at the annual team meetings observed. Data from assessments was entered into these two forms so that team members could reference current assessments when developing necessary supports. The unified record was available at the meeting and was used by the team when additional information was needed. • At the ISPA Individual #261 for a living options discussion, the psychologist used the active record to look at data. She did not, however, find all of it, saying that a delay in document filing into the record was due to the record clerk being out. • At the ISPA Individual #484 for a living options discussion, the psychologist used the active record to review observation notes. • At the CLDP meeting for Individual #406, the nurse used the active record to report on information about the individual's diabetes/insulin, and later for information regarding ophthalmology. • The active record was used during psychiatric clinic meetings. • For some habilitation-related meeting, including PNMT, the active records were not used, however, it was evident that a record review was conducted by each team member prior to the meetings, and details were reported and added to the meeting minutes.	

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
ART	Administrative Review Team
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
CMD	Choking, Modified Barium Swallow Study, and Dysphagia Committee
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
COS	Change of Status
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
COS	Change of Status
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
DDI	Drug Drug Interaction
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
DPN	Dental Progress Note

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
DSP	Direct Support Professional
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
GA	General Anesthesia
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
HCV	Hepatitis C Virus
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 Case Analysis
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ICO	Infection Control Officer
ICP	Infection Control Preventionist
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
IPMP	Integrated Pest Management Plan
IPN	Integrated Progress Note
IPSD	Integrated Psychosocial Diagnostic Formulation
IRR	Integrated Risk Rating
IRRF	Integrated Risk Rating Form
IRT	Incident Review Team
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
LTBI	Latent TB Infection
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
MIT	Mealtime Improvement Team
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
MTC	Meal Time Coordinator
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
PMR	Protective Mechanical Restraint
PMRP	Protective Mechanical Restraint Plan
PMRQ	Psychiatric Medication Review Quarterly
PNE	Pneumonia
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
QIDP	Qualified Intellectual Disabilities Professional
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
RPN	Risk Priority Number
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
SIT	Skin Integrity Team
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
TLSO	Thoracic Lumbar Sacral Orthotic
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
VAP	Vascular Access Port
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