United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

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Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICFMR) component of Rio Grande State Center.

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

In order to conduct reviews of each of the areas of the Settlement Agreement, each Monitor 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 ensured that the monitoring team received documents, she assisted with scheduling, and she played an important role in the facility's PET program, which directly related to the Settlement Agreement.

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

- There were 246 restraints used for crisis intervention involving 42 individuals between 11/1/13 and 5/30/14, a slight decrease since the last onsite review. Individual #483 accounted for 50 (20%) restraints used for crisis intervention. The three individuals with the greatest number of restraints accounted for 35% of the restraints.
- There were no instances of dental/medical restraint used for routine medical or dental exams from 11/1/13 through 5/31/14. The facility reported that 11 individuals at the facility wore protective mechanical restraints (PMRs) classified as medical restraint by the facility to prevent self-injurious behavior.
- The facility needs to ensure that protective mechanical restraint plans are developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation.

Abuse, Neglect, and Incident Management

- Much progress was made and the facility met substantial compliance with all of the sections of this provision. In particular, the facility had focused on section D4 regarding the use of trended data to make intervention decisions, implementing these actions, following them to completion, and making revisions as needed.
- There were 593 allegations of abuse, neglect, or exploitation conducted by DFPS at the facility between 11/6/13 and 4/30/14. From these, there were 10 confirmed cases meeting the definition of physical abuse and 20 meeting the definition of neglect.
- There were a total of 697 injuries reported between 12/1/13 and 5/31/14 that included 22 serious injuries resulting in fractures or sutures. This was an overall decrease in the number of injuries reported the previous six-month period. Injury trends were being generated by individual and were given to IDTs for planning.
- While the incident management and quality assurance departments were placing a greater focus on identifying trends of incidents and injuries, it was still not evident that IDTs were adept at revising supports and monitoring implementation following incidents. IDTs need additional training on using trend information to develop individualized supports to reduce the occurrence of incidents and injuries. IDTs should analyze data regarding incidents and injuries frequently to assess the effectiveness of supports.

Quality Assurance

- The QA program at MSSLC made more progress than ever before, including achieving substantial compliance with sections E3 and E4. Although there was not yet a complete and adequate data list inventory, there was progress due to efforts by the QA director in working directly with department and section leaders.
- Of the 16 inventories, 16 (100%) included data that could be used to identify trends as required in the wording of section E1; 10 (63%) included a wide range of data; 16 (100%) included what appeared to be key indicators; 0 (0%) described the data being collected (most labeled the data item, but did not describe what data were being collected);

and 12 (75%) included a self-monitoring tool. None (0%) of the items were categorized as a process or an outcome indicator.

- The items in the inventory lined up with what was in the matrix, but did not line up with what was in the QA report and what was presented to QAQI Council.
- Data for 20 of the 20 (100%) sections of the Settlement Agreement were summarized, however, few sections analyzed data across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals.
- A QA report was issued twice each month. Of the 20 sections of the Settlement Agreement, 20 (100%) appeared in a QA report at least once each quarter. The reports did not contain any type of narrative analysis (most had either no narrative or a narrative that described the data). QAQI Council met twice each month.
- There were 10 active CAPs; three were in the new format. More work was needed to define criteria for achieving a CAP (E2) and managing revisions when needed (E5).

<u>Integrated Protections, Services, Treatment, and Support</u>

- There was little progress in developing an adequate IDT process for developing, monitoring, and revising treatments, services, and supports for each individual. Recent turnover in the QIDP department had impacted progress made during previous visits.
- The facility implemented a section F PET. The QIDP Director met monthly with the QA Director to review progress with the requirements of the Settlement Agreement. An ISP workgroup was recently established consisting of the QIDP Educator, QIDP Director, Assistant QIDP Director, QA staff, and representatives from the medical, behavioral health, and habilitation therapies department.
- Two annual ISP meetings were observed during the monitoring visit. Both IDTs were struggling with the statewide ISP planning process and what the resulting outcome should be. Both meetings observed were lengthy and did not result in a plan that would ensure meaningful programming and supports. The IDTs did not develop outcomes that would build on what the individuals were currently doing to offer new experiences or opportunities to learn new skills based on identified preferences. It was not clear that supports developed by the IDT were either meaningful or functional for the individual.
- The facility did not have an adequate system in place to ensure that plans were implemented and supports were monitored for efficacy. At ISP meetings observed, the IDT was unable to determine whether or not progress had been made towards outcomes or whether supports were effective, in some cases. Some data were presented regarding supports in place, however, team members were not sure what the data represented or specifically what progress had been made. Consequently, few changes were made to supports and services even when progress was not evident.

Integrated Clinical Services

- The monitoring team found evidence of integration of clinical services, but there was no significant progress seen in this area. There was no overarching plan to move forward in this area and there was no specific policy related to integration of clinical services.
- Many staff believed they worked to provide services in an integrated manner, but some expressed concerns, specifically citing the need to have greater participation of the medical staff in the risk process.
- 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.
  There was significant improvement on the part of the primary providers in the completion of the IPN entries for outside consultations. This improvement was first noted with the implementation of the revised IPN format in October 2013. The subsequent revision implemented in February 2014 resulted in even further improvements resulting in this provision moving into substantial compliance.

Minimum Common Elements of Clinical Care

- MSSLC made no progress in this provision. A policy for the minimum common elements of clinical care was approved in May 2013, but there was no plan for how the facility would move towards substantial compliance in this area.
- MSSLC was tracking assessments, but this was limited to timeliness only. There was no documentation provided relative to the quality of the assessments. There was also no review of any unscheduled/interval assessments.
- It was not clear why progress had halted. Clinical indicators were developed at the time of the December 2013 compliance review, but no further work on this was presented. Some clinical staff reported during the week of the compliance review that they worked on section H. However, the products of this work were not presented to the monitoring team.

At-Risk Individuals

- The facility was in the process of retraining QIDPs and IDTs on completing the risk identification process. A large turnover in the QIDP department had necessitated new training on the risk process.
- The monitoring team observed the risk identification process at two ISP meetings and noted progress. Notably, each discipline presented relevant information during the risk determination process that was essential for determining risk in each area identified by the IRRF. Both teams engaged in integrated discussion regarding the identification of risks, however, both IDTs had difficulty establishing consensus among disciplines regarding risk factors that impacted risk ratings. For example, Individual #519's IDT engaged in a long debate regarding how insomnia impacted his risks. Without consistent data regarding his sleep patterns, the team was unable to reach a consensus.

- The facility continued to struggle with ensuring that all assessments were completed and available for review prior to annual ISP meetings. Without up-to-date assessment information, it was unlikely that accurate risk ratings could be assigned during annual IDT meetings.
- As noted in section F, the facility did not have an adequate system in place to monitor supports. 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.

Psychiatric Care and Services

- MSSLC met substantial compliance for six sections of provision J (J1, J5, J6, J7, J14, J15). The department had a full time lead psychiatrist and four other full time equivalent board eligible/board certified psychiatrists.
- 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 behavioral health with regard to the collaborative case formulation, diagnostic concordance between disciplines, and the identification of target data points for monitoring.
- 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. There were, however, noted deficiencies with regard to the timeliness of submission of clinical documentation.
- In regard to pretreatment sedation, there was minimal pretreatment medication administered at MSSLC, with the majority being given at another location. This did not, however, free the facility of its responsibility to log, cite, and monitor individuals who had received pretreatment sedation elsewhere and then returned to MSSLC.
- There were onsite neuropsychiatric clinics that took place at MSSLC since last review. The neurologist had 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 the four items (K2, K3, K8, and K11) that were in substantial compliance prior to this review, and demonstrated improvements in several additional items. These improvements included an increase in the flexibility of the data collection system, improvement in data collection timeliness, improved evidence of data-based treatment decisions, and establishment of goal frequencies of data collection timeliness, IOA, and treatment

integrity. Moreover, there was continued development of behavioral systems to ensure that PBSP data were recorded in a timely fashion, were reliable, and that PBSPs were implemented as written.

- To continue to move forward the facility needs to demonstrate that the established frequencies and levels of data timeless, IOA, and treatment integrity are achieved. Further, there needs to be an increase in the percentage of individuals with a full psychological assessment, the percentage of current functional assessments completed for individuals with PBSPs, and the percentage of individuals with annual psychological assessments. PBSPs need to be consistently implemented within 14 days of receiving consent.

Medical Care

- Progress was seen in a number of areas of medical care. Staffing for the department had stabilized with no changes since the last compliance review. Preventive care continued to improve with the number of individuals who completed cancer screenings increasing. This was important because completion of these screenings allowed for early detection of disease that had the potential to have untoward outcomes. The provision of immunizations also improved. For a particular immunization, the database usually documented the number of immunizations received, the antibody status, or refusal.
- Annual Medical Assessments were completed in a timely manner, but they continued to need work. Quarterly Medical Summaries were inconsistently found in the records reviewed. For the record sample reviewed, documentation of care improved.
- Health care organizations can no longer afford to not develop medical quality programs, and the health care services division of MSSLC is no different. The medical director will not know if the efforts of the department are succeeding if they are not measured appropriately. Adequate corrective action and performance improvement cannot be implemented without measurement and analysis.
- Fundamental to the framework of a medical quality program is the development of a robust set of policies and procedures that guide health care services. Because health care practices are to some extent fluid, policy and guideline review and revision is important.

Nursing Care

- MSSLC maintained substantial compliance with M4 and M6 and met substantial compliance with M2. The CNE and NOO assured there were ongoing measurable performance objectives for nursing in adhering to policies/ procedures/protocols, and lack of adherence/failures were addressed with the appropriate remediation.
- The RN Compliance nurse conducted ongoing state approved audits. She was observed many times on the units providing constructive re-education and mentoring to nurses, as part of the real-time audit process.

- The Hospital Liaison had been instrumental in assisting the facility in gaining remote access to real-time hospital records. The Hospital Liaison continued to make daily visits/contact, attend ISPA meetings, and track movement of individuals within the facility.
- The facility continued to refine its practices of ensuring that new nurses, when hired, were sufficiently trained, including classroom and bedside competencies, and that each was assigned a preceptor. New RN Case Managers caseloads for adding individuals was a gradual process and based on levels of competencies obtained by the RN Case Manager.
- The nursing assessments for reporting and responding to individuals with acute illness or injury were consistent in addressing/documenting their health care needs, timely notification to practitioners, and followed established nursing protocols.
- Staff were observed in many areas by the monitoring team, at different times of the early morning, day, and evening. Standard precautions were observed being adhered to and hand hygiene techniques were followed.
- The facility had implemented a process for a multidisciplinary review of all medication errors by Nursing, Medical, and Pharmacy, as recommended by the monitoring team. The facility continued to maintain its robust systems of collecting and analyzing medication variances, addressing medication variances, and where risks are identified, producing solutions to reduce or minimize harm.

<u>Pharmacy Services and Safe Medication Practices</u>

- The provision of pharmacy services was impacted by significant changes in the pharmacy department. Communication between the pharmacists and prescribers continued and there was documentation of this communication.
- Compliance with timely completion of the QDRRs was gradually improving, but compliance rates had dropped to such low rates that reaching an acceptable compliance rate will require vigilance on the part of the pharmacy staff.
- Monitoring for metabolic syndrome continued to present challenges for the facility. Individuals who potentially had the diagnosis of metabolic syndrome were not thoroughly reviewed to make a final determination regarding the presence of the diagnosis.
- There was progress seen in the medication variance system. Processes were implemented to ensure the accuracy of data through collaboration between medical, pharmacy, and nursing. The nursing department had done a substantial amount of work in many areas and provided evidence of corrective actions that occurred with staff. Similar efforts were needed in the medical and pharmacy departments.
- Every provision item in this section should be discussed directly or indirectly in the Pharmacy and Therapeutics Committee meeting. The facility conducted a Pharmacy and Therapeutics Committee meeting on 12/10/13, which was the week of the last compliance review. The next meeting was held on 4/29/14. This was nearly five months after the previous meeting.

Physical and Nutritional Management

- The facility maintained substantial compliance with section O1 and achieved substantial compliance with sections O4 and O5. There continued to be a full PNMT and team members appeared to be working well together.
- Mealtimes continued to show improvements in both the Martin and Barnett units. The primary concerns were related to content in the Dining Plans that outlined specialized techniques. Staff were attempting to follow these instructions, but were not competent and skilled. Non-foundation training may be indicated in these cases because these would not be skills generally trained in NEO. Monitoring was being conducted by therapy clinicians only, and a very limited number of these were related to mealtimes. PNMPCs did not conduct any monitoring, though there was a plan to reinstitute this in the near future.
- Positioning had also improved based on the observations by the monitoring team. In a few instances, the staff did not recognize the need to re-position the individuals and required prompting and instruction. This again should be readily identified and corrected through compliance and effectiveness monitoring.

Physical and Occupational Therapy

- There were limited improvements in the provision of OT/PT supports and services. The essential element sections should be carefully reviewed so that content of some elements can be further refined.
- OT/PT-related supports and services must be better integrated into the ISP. Supports introduced in the interim must be reflected via assessment and also be reflected in an ISPA. The clinicians should continue to be challenged to examine the existing plans to determine if supports are effective, but also least restrictive.
- There were improvements in the implementation of PNMPs for health and safety in the Martin unit. Also, there were a number of individuals engaged in direct OT and/or PT services.

Dental Services

- The dental department continued to make incremental measures of progress. Individuals were seen in a timely manner for annual and initial assessments and documentation of the assessments continued to improve. The suction toothbrushing program was expanded and additional oversight was implemented to ensure that treatments were adequately completed. The facility reported very few individuals with poor ratings.
- Compliance with obtaining radiographs improved with less than 10% of individuals having outstanding needs for radiographs.

- The facility did not use pretreatment sedation or TIVA on campus. Contracts for completing general dentistry work with sedation and/or anesthesia had been recently executed. This represented a significant accomplishment for the facility and the dental director should be commended for moving forward and securing such important services for the individuals.
    - No individuals had actually yet completed any treatment through the providers, though a few individuals had undergone initial evaluations. The result of not being able to do general dental procedures with sedation/anesthesia was that individuals did not have access to these services.
    - Some individuals ultimately received services by an oral surgeon and had procedures expanded due to "rampant" decay and gross caries. Some of these individuals had lived at MSSLC for several years.
- The facility will need to demonstrate that it is adequately providing services in order to move towards achieving substantial compliance.

<u>Communication</u>

- There was a weakness in the assessment process to determine AAC needs in both Comprehensive Assessments and Assessments of Current Status. Timeliness of assessments was poor, though attendance at ISPs was improved.
- A number of individuals participated in traditional speech therapy for articulation disorders. The documentation of this therapy was consistent and appropriate.
- There was no clear evidence of an effort to work collaboratively with behavioral health to develop communication strategies that were well integrated into the PBSP and throughout the daily routine.
- SAPs related to communication were developed by the program developers, but with little evidence of participation by the SLPs in their development, implementation, or review.

<u>Habilitation, Training, Education, and Skill Acquisition Programs</u>

- The monitoring team noted several improvements since the last review. These included improvement in the quality of SAPs, the addition of SAM/HIP to the new SAP format, an increase in the percentage of SAPs reviewed that were clearly based on assessment results, and establishment of SAP integrity goals. The facility also established individualized day treatment engagement goals and goals for community outings and training.
- Positive working relationship with the local public school district continued to result in benefits to the students, including increase graduations, attendance, and incorporation of ARDIEP content into the ISPs.
- The monitoring team suggests that the facility ensure that SAP training instructions are clear and tailored to individual needs, expand the SAP training methodologies used, and ensure that SAP graphs measure behavior that clearly reflects progress toward learning objectives. The facility also should modify the SAP integrity scoring to ensure that it adequately assesses if staff are implementing SAPs as written, and ensure that established SAP integrity goals are achieved. Engagement goals and community SAP training should be achieved.

Most Integrated Setting Practices

- There were again staffing and leadership changes in the admissions and placement department, including a new APC. The number of individuals placed was at an annual rate of about 21%, an increase since the last review. 31 individuals were placed in the community since the last onsite review. 58 individuals were referred for placement since the last onsite review, the most in any six-month period to date. 65 individuals were on the active referral list.
- Placements were slowed by the absence of providers who could meet the physical and accessibility needs of individuals, and the absence of providers willing and capable of supporting individuals with complex behavioral and psychiatric histories who also were alleged offenders.
- Of a sample of 8 ISPs, all of the written assessments for 0 individuals (0%) included an applicable statement or recommendation from all disciplines regarding referral to the community. However, during the actual ISP meeting, professionals gave their opinions. Even so, thorough discussions of living options were not conducted for most individuals.
- Discharge assessments did not address the individual's new home, day program, or employment settings and how supports might need to be provided in a different manner in these new settings.
- CLDPs did not clearly identify a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition by including documentation to show that adequate training of community provider staff occurred and that there was sufficient collaboration with the new provider.
- The CLDP list of pre and post move supports were not comprehensive. That is, they did not address all of the areas that needed to be addressed for the individual's unique needs, especially regarding behavioral, psychiatric, and crisis interventions.
- The facility obtained substantial compliance with T2a and maintained substantial compliance with T2b. Post move monitoring was done thoroughly, on time, and in all settings.

Guardianship and Consent

- The HRO continued to offer assistance with the application process for correspondents who were considering obtaining guardianship. IDTs continued to complete the Determination of Need for guardianship or advocates. The facility had an active Human Rights Committee that reviewed all restrictions. The HRO continued to facilitate the self-advocacy group meetings.
- 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.

Recordkeeping Practices

- There was progress across all four of the sections of this provision. Substantial compliance was maintained for V1. Sixteen of 16 (100%) individuals' records reviewed included an active record, individual notebook, and master record. A unified record was created for all new admissions.
- 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 2-3 errors/missing documents per active record.
- Active records remained in overall good shape. Individual notebooks continued to be used for all individuals and as per state policies.
- For section V2, a well-organized system was now in place. With the completion of the remaining policies and the completion of the training of the remaining staff, the facility should be able to obtain substantial compliance.
- Five quality assurance reviews (audits) were conducted in each of the previous six months. All of the reviews were done in a fairly consistent manner. Errors were reported to the responsible person and follow-up occurred for two months. A small percentage of errors (less than a third), however, were corrected.
- A set of appropriate graphs and data were not being kept and, in part, as a result, the type of analysis and action planning required by this section were not done.

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 #00.2
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: 20 records of restraints used in a crisis intervention for five 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>#451</td><td>Physical</td><td>4/12/14</td></tr>
<tr><td>#451</td><td>Physical</td><td>2/20/14 @ 6:55 am</td></tr>
<tr><td>#451</td><td>Physical</td><td>2/20/14@ 7:00 am</td></tr>
<tr><td>#451</td><td>Physical</td><td>2/20/14 @ 8:38 am</td></tr>
<tr><td>#451</td><td>Physical</td><td>2/20/14 @ 9:06 am</td></tr>
<tr><td>#451</td><td>Physical</td><td>2/20/14 @ 9:13 am</td></tr>
<tr><td>#451</td><td>Chemical</td><td>2/20/14 @ 9:38 am</td></tr>
</table>
</td></tr>
</table>

#466	Physical	4/7/14
#466	Physical	3/24/14
#466	Physical	3/19/14
#466	Physical	2/6/14
#466	Physical	2/6/14
#466	Physical	1/31/14
#483	Physical	4/19/14
#483	Physical	4/10/14 @ 9:23 am
#483	Physical	4/10/14 @10:03 am
#483	Physical	4/10/14 @ 10:09 am
#15	Physical	4/27/14
#398	Physical	4/26/14 @ 3:50 pm
#398	Physical	4/26/14 @ 4:20 pm
#297	Chemical	2/21/14

- Sample #C.2 was documentation for a selected sample of 20 staff:
  - their start dates,
  - the dates they were assigned to work with individuals,
  - their training transcripts showing date of most recent:
    - PMAB training and
    - Training on the use of restraint.

- Sample #C.3 was a sample of documentation for pretreatment sedation chosen from the last ten medical/dental restraints (none submitted) including the physicians' orders for the restraint, 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 desensitization plan.

- Sample #C.4 (a subsample of #C.1) chosen from II.5a in response to the document request.

Individual	Date
#451	2/20/14
#297	2/21/14

- Sample #C.5: Was selected from a sample of restraints that occurred off-campus. The facility reported only one restraint.

Individual	Date
#483	3/17/14 @ 12:45 pm
#483	3/17/14 @ 1:25 pm

- Sample #C.6: A sample of individuals who were restrained more than three times in a rolling 30-day period:

- Sample #C.7 was not used was documentation for a selected sample of individuals for whom protective mechanical restraints were used in the past six months.

Individual	Date	Restraint Type
#518	4/16/14	Binder
#84	4/16/14	Binder
#143	4/16/14	Binder
#293	4/15/14	Mittens

Interviews and Meetings Held:
- Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs;
- Charlotte M. Kimmel, Director of Behavioral Services
- Patrick Samuels, Incident Management Coordinator
- Ramona Echols, QIDP Director
- Craig Burgess, Assistant QIDP Director
- Don Morton, Assistant Director of Programs

Observations Conducted:
- Observations at residences and day programs
- Incident Management Review Team Meeting 6/2/14 and 6/3/14
- Longhorn Morning Unit Meeting 6/4/14
- PET II Meeting for sections C, D, K, and J
- ISP preparation meeting for Individual #539
- Annual IDT Meeting for Individual #557 and Individual #519
- ISPA for Individual #4511 regarding restraints

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 Director of Behavioral Services was responsible for the self-assessment process. She engaged in a self-assessment process that included a review of all restraint documentation for crisis intervention restraints, review of medical restraint documentation, and review of all protective mechanical restraints. The facility had a good self-assessment process in place.

	The facility assigned a self-rating of substantial compliance to C2, C3, C4, C6, and C8. The monitoring team could not confirm compliance with the requirements of C4 based on the sample reviewed.
	Summary of Monitor's Assessment: Based on a list of all restraint data provided by the facility, there were 246 restraints used for crisis intervention involving 42 individuals between 11/1/13 and 5/30/14. The number of restraint incidents had increased slightly since the last onsite review when there had been 238 restraints during the review period. Individual #483 accounted for 50 of the 246 (20%) restraints used for crisis intervention. The three individuals with the greatest number of restraints accounted for 35% of the total restraints. A log of all dental/medical restraints provided by the facility showed no instances of dental/medical restraint used for routine medical or dental exams from 11/1/13 through 5/31/14. The facility reported that 11 individuals at the facility wore protective mechanical restraints (PMRs) classified by the facility as medical restraint to prevent self-injurious behavior. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting compliance with the requirements of section C. Observations in the homes and day programs and interviews with staff were conducted the week of the monitoring visit to gain additional information. The facility was in compliance with five of eight provision items in section C and with parts of C7, The facility maintained compliance in regards to documentation and review of crisis intervention restraints. To move forward, the facility should continue to focus on: • Ensuring that nursing reviews for all restraint incidents are completed and appropriately documented following state policy guidelines. • Ensuring protective mechanical restraint plans are developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation. • Ensuring that restraints are not implemented that are contraindicated due to health concerns or restrictions.

<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.6),

<table>
<tr><th>Type of Restraint</th><th>June 2013-Nov 2013</th><th>Nov 2013-May 2014</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>224</td><td>243</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>9</td><td>3</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>238</td><td>246</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>58</td><td>42</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>25</td><td>18</td></tr>
<tr><td>Medical/dental restraints</td><td>0</td><td>0</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>0</td><td>0</td></tr>
<tr><td>Protective mechanical restraints</td><td>12 individuals</td><td>11 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 11/1/13 and 5/30/14) prone restraint was not identified.

A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises between 12/1/13 and 5/30/14. Sample #C.1 was a sample of 20 restraints for six individuals, representing 8% of restraint records over the last six-month period and 14% of the individuals involved in restraints. The sample included 18 physical restraints and two chemical restraints. Sample #C.1 included three individuals with the greatest number of restraints, as well as three 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 six 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 20 of the 20 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • g. For the 20 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 20 (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 20 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 20 restraints, involving six individuals, 20 (100%) were approved restraints. k. In 19 of 20 of these records (95%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. • The behavior resulting in restraint for Individual #466 began when the individual was told that he could not go on a planned outing in the community due to a shortage of staff. l. The facility reported that there were 11 individuals subjected to restraints classified as protective mechanical restraints (PMRs). Eleven of those had binders and two had helmets and mittens, as well. Of the11 restraints reviewed that were considered to be PMR by the facility, four were reviewed by the monitoring team (Sample C.7). Of these, one (25%) followed state policy regarding the use, management, and review of PMR. Individual #293 had a protective mechanical restraint plan in place to provide guidance for implementation, monitoring, and fading of the restraint. The facility reported that protective mechanical restraint plans were being developed for the other individuals, however, had not yet been finalized.	

#	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: 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.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	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
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample #C.2 was randomly selected from a current list of staff. b. A sample of 20 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: • 20 of the 20 (100%) had current training in RES0105 Restraint Prevention and Rules. • 17 of the 17 (100%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training • 20 of the 20 (100%) had completed PMAB training within the past 12 months. • 17 of the 17 (100%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training.	Substantial Compliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical	a. Based on a review of 20 restraint records (Sample #C.1), in 20 (100%) there was evidence that documented that restraint was used as a crisis intervention. See C1f. b. Six of six individuals in the sample had a Positive Behavior Support Plan in place. In review of Positive Behavior Support Plans for six individuals in the sample, there was no	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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 20 of 20 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders. • Individual #451, however, was physically restrained four times on 5/30/14 in contradiction to the facility "Do Not Restrain" list. The physician placed him on the list pending hip replacement surgery on 5/8/14 for 180 days. Following the review, the state office reported that horizontal restraints are the only restraint not to be used by staff when restraining Individual #451. This needs to be clearly stated on the "Do Not Restrain" list and in his record to avoid confusion by staff providing supports. 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. f. In 20 of 20 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. Based on this review, the facility was not in substantial compliance with C4. To gain substantial compliance, the facility needs ensure that restraint is not used in contradiction to medical orders.	
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	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. Eleven campus coordinators had been deemed competent to monitor restraints. c. Based on review of document request II.19, staff who performed the duties of a restraint monitor (100%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Based on a review of 20 restraint records (Sample #C.1), a face-to-face assessment was conducted: • d. In 20 out of 20 incidents of restraint (100%) by an adequately trained staff member. • e. In 19 out of 20 instances (95%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. The exception was: o Individual #466 on 3/25/14. – restraint monitor was not notified of the restraint until the following day. • f. In 20 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • g. In 20 instances (100%), the documentation showed that an assessment was completed of the consequences of the restraint. A sample of ___ records for which physicians had ordered alternative monitoring schedules was reviewed. (none in sample) • h. In ___ out of ___ (___%), the extraordinary circumstances necessitating the alternative monitoring were documented; and • i. In ___ out of ___ (___%), the alternative monitoring schedules were followed. Based on a review of 20 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 18 (90%) of the instance of restraint. The exceptions were: o Individual #466 on 3/25/14 (late) o Individual #483 on 4/9/14 (late) • k. Monitored and documented vital signs in 20 (100%). • l. Monitored and documented mental status in 20 (100%). Based on documentation provided by the facility, six restraint incident had occurred off the grounds of the facility in the last six months. A sample of two restraint incident was reviewed (sample #C.5). • m. Conducted monitoring within 30 minutes of the individual's return to the facility in two out of two (100%). • n. Monitored and documented vital signs in two (100%). • o. Monitored and documented mental status in two (100%). Sample #C.7 was selected from the list of individuals who had protective mechanical restraint in the last six month. For these individuals, • p. In four (100%) out of four, the physician specified the schedule of monitoring required or specified facility policy was followed; and	

#	Provision	Assessment of Status	Compliance
		• q. In four (100%) out of four, the physician specified the type of monitoring required if it was different than the facility policy. • r. In four (100%) out of four of the medical restraints, appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Based on this review, the facility was in substantial compliance with this provision.	

C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample (Sample #C.1) of 20 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 20 (100%), continuous one-to-one supervision was provided;
		• b. In 20 (100%), the date and time restraint was begun;
		• c. In 20 (100%), the location of the restraint;
		• d. In 20 (100%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. See C.1.g.
		• e. In 20 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. See C.1.h.
		• f. In 20 (100%), the specific reasons for the use of the restraint;
		• g. In 20 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint;
		• h. In 20 (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:
		  ○ i. In 20 (100%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration).
		  ○ j. In ___ (n/a) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint. The longest physical restraint in the sample was 10 minutes.
		  ○ k. In ____ (n/a), 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.
		• l. In 20 (100%), the level of supervision provided during the restraint episode;
		• m. In 20 physical restraints (100%), the date and time the individual was released from restraint; and
		• n. In 17 (85%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. The exceptions was:
			Substantial Compliance

#	Provision	Assessment of Status	Compliance
		○ Individual #466 dated 2/6/14 ○ Individual #398 dated 4/26/14 (x2) o. In a sample of 20 records (Sample #C.1), restraint debriefing forms had been completed for 20 (100%). p. A sample of zero individuals subject to pretreatment sedation for medical treatment was reviewed (Sample #C.3-none submitted), and in (n/a), there was evidence that the monitoring had been completed as required by the physician's order or state policy. q. In two (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the behavior specialist or psychiatrist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to MSSLC documentation, during the six-month period prior to the onsite review, nine individuals were placed in restraint more than three times in a rolling 30-day period. This represented a slight improvement compared to the last review when 10 individuals were placed in restraint more than three times in a rolling 30-day period. Three (i.e., Individual #466, Individual #157, and Individual #284) of these nine individuals (33%) were reviewed by the monitoring team to determine if the C7 requirements of the Settlement Agreement were met. Their PBSPs, crisis intervention plans, and most recent individual support plan addendums (ISPAs) that occurred as a result of more than three restraints in a rolling 30-day period were reviewed. The results of this review are discussed below with regard to sections C7a through C7g. MSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as being in noncompliance, however, because only two of the three ISPA's reviewed (67%) reflected a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, <u>and</u> a plan to address them. Individual #157's ISPA minutes did reflect a discussion suggesting that psychosocial issues and the lack of family involvement may have contributed to an increase in his physical aggression that provoked restraint. Additionally, the minutes of his ISPA	Noncompliance

#	Provision	Assessment of Status	Compliance
		reflected providing consultation services to Individual #157 to address these psychosocial issues. Individual #466's ISPA also reflected a discussion suggesting that psychosocial issues, missing his family, may have contributed to his physical restraints. No action or plans, however, to attempt to address these psychosocial issues were documented in the ISPA. In order to achieve substantial compliance with this provision item, the minutes from at least 85% of the individual 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;	MSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as being in noncompliance, however, because none of the three ISPA meeting minutes reviewed (0%) reflected a discussion of possible contributing environmental factors, and if environmental factors had been identified, suggestions for modifying them to prevent the future probability of restraint. Individual #284's ISPA meeting minutes indicated that chaotic environments may contribute to an increase in his dangerous behavior, but no action to mitigate the effects of chaotic environments (e.g., attempts to remove him when the environment became chaotic, etc.) were reflected in the ISPA minutes. 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 possibly contributing environmental conditions (e.g., noisy environments), 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 provoking restraints;	This item is concerned with a review of potential environmental antecedents to the behaviors that provoke restraint. MSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as being in noncompliance, however, because none of 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. MSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as in noncompliance because, although all three ISPAs reviewed included a review of potential maintaining variables, none of the ISPA minutes reviewed (0%) reflected a discussion of a plan to address the maintaining variables. In order to achieve compliance with this provision item, the minutes from at least 85% of the ISPA minutes reviewed should reflect a discussion of the variables maintaining the dangerous behavior (e.g., staff attention) that provokes restraint, and 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 of the PBSPs and crisis intervention plans reviewed for individuals who were placed in restraint more than three times in a rolling 30-day period included the components discussed below. Therefore, this item was rated in substantial compliance. 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, • All three PBSPs reviewed (100%) 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 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, and • For all three (100%) the criteria for terminating the use of the restraint were specified.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(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%) of the 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 was rated as being in substantial compliance because all three of the ISPAs reviewed (100%) documented that the PBSPs were evaluated, and revised if necessary. In order to maintain substantial compliance with this provision item, at least 85% of the individuals who were placed in restraint more than three times in a rolling 30-day period should have evidence (in the ISPA) of a review, and revision when necessary, of the current PBSP.	Substantial Compliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The facility had a restraint review system in place for all crisis intervention restraints. All restraints continued to be reviewed by the behavior specialist, unit directors, and IMRT. A sample of documentation related to 20 incidents of crisis intervention restraint was reviewed (Sample #C.1), this documentation showed that: • a. In 20 (100%), 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. • b. In 20 (100%), 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. • c. In 20 (100%), the circumstances under which the restraint was used was determined and is documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • d. In 20 (100%), the review conducted by the restraint monitor and/or behavior specialist 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 restraint monitor, behavior specialist, and/or the unit director did not documented recommendations from their review for the restraints in sample	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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. The facility continued to use video review of restraints to determine if restraints could have been avoided or implemented more safely. Sixty-two video reviews were completed by administrative staff between 10/1/13 and 3/31/14. Follow-up to recommendations made during video reviews were documented on the Restraint Video Review Form. Based on this review, the facility maintained substantial compliance with review requirements.	

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 Incident Management Review Committee meeting minutes for each Monday of the past six months o Unit Meeting Minutes for the past six months o QA/QI report for the past two quarters o Abuse/Neglect/Exploitation Trend Reports for the past two quarters o Injury Trend Reports for the past two quarters 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 12/1/13 o All injury report for the past six months for any individual sustaining a serious injury o List of all ANE allegations since 12/1/13 including case disposition o A list of all investigations completed by the facility in the last six months. o List of employees who failed to report A/N/E (0) o List of employees reassigned due to ANE allegations o Spreadsheet showing background check for all employees o List of employees terminated based on background checks o MSSLC CAP Implementation Form for completed investigation o ISP, ISPAs, and QIDP monthly reviews for Individual #113 o ISPs for Individual #884, Individual #386, Individual #261, Individual #211, Individual #80, Individual #816, Individual #521, and Individual #535. o Documentation from the following completed investigations, including follow-up:

Sample D.1.	**Allegation**	**Disposition**	**Date Reported**
#43089378	Emotional/Verbal Abuse (2)	Unconfirmed (2)	4/6/14
#43082033	Physical Abuse (2)	Unconfirmed (2)	4/1/14
#43078760	Neglect (2) Physical Abuse	Confirmed (2) Confirmed	3/30/14
#43066671	Neglect (2)	Confirmed (1) Unconfirmed (1)	3/20/14
#43061805	Neglect (2)	Confirmed (1)	3/16/14

		Unconfirmed (1)	
#430056591	Exploitation	Referred Back	3/11/14
#43049309	Physical Abuse	Unconfirmed	3/4/14
#43033066	Physical Abuse	Unconfirmed	2/19/14
#43032471	Neglect	Unconfirmed	2/18/14
#43025645	Neglect (2)	Unconfirmed (2)	2/12/14
#43009426	Emotional/Verbal Abuse Neglect Physical Abuse	Unconfirmed Unconfirmed Confirmed	1/29/14
#43005189	Emotional/Verbal Abuse	Unconfirmed	1/25/14
#43003741	Exploitation (2)	Inconclusive Other	1/24/14
#42982738	Emotional/Verbal Abuse (2) Exploitation	Unconfirmed (2) Inconclusive	1/6/14
Sample D.2	**Type of Incident**	**Date Incident Occurred**	
#3136	Serious Injury Peer to peer aggression	4/18/14	
#3132	Serious Injury Determined Cause	4/16/14	
3074	Serious Injury Peer to peer aggression	3/31/14	
#3057	Sexual Incident	3/25/14	
#3028	Unauthorized Departure	3/12/14	
#2965	Unauthorized Departure	2/16/14	
#2920	Serious Injury Peer to peer aggression	2/2/14	
#2815	Serious Injury Peer to peer aggression	12/28/13	

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs;
- Charlotte M. Kimmel, Director of Behavioral Services
- Patrick Samuels, Incident Management Coordinator
- Ramona Echols, QIDP Director
- Craig Burgess, Assistant QIDP Director
- Don Morton, Assistant Director of Programs

	Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 6/2/14 and 6/3/14 o Longhorn Morning Unit Meeting 6/4/14 o PET II Meeting for sections C, D, K, and J o ISP preparation meeting for Individual #539 o Annual IDT Meeting for Individual #557 and Individual #519 o ISPA for Individual #451 regarding restraints
	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 implemented an audit process using similar activities implemented by the monitoring team to assess compliance. The facility had developed a protection from harm monitoring tool. The facility looked at other applicable documentation relevant to each provision. For example, for D1, the facility reviewed policies, training records to ensure that all staff had completed required training on unusual incidents. The facility's review of its own performance found compliance with 21 of 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with 22 of 22 provisions. The facility did not rate D4 in substantial compliance, although the IMC noted that significant progress had been made to address this provision. The monitoring team agreed that the facility needs to continue to focus on identifying and addressing trends related to incidents and injuries, however, it a system was now in place to effectively do this. Further self-assessments should focus on the quality of recommendations and follow-up to issues noted during the investigation process and positive outcomes in reducing the number of incidents and injuries at the facility.

	Summary of Monitor's Assessment: According to a list of all abuse, neglect, and exploitation investigations, there were investigations involving 593 allegations of abuse, neglect, or exploitation conducted by DFPS at the facility between 11/6/13 and 4/30/14. From these 593 allegations, there were: • 229 allegations of physical abuse including, o 10 confirmed o 127 unconfirmed o 3 inconclusive o 69 unfounded o 1 referred back for further investigation o 6 other o 13 pending • 176 allegations of verbal/emotional abuse including, o 0 confirmed o 83 unconfirmed o 86 unfounded • 21 allegation of sexual abuse including o 0 confirmed o 2 unconfirmed o 18 unfounded o 1 inconclusive • 158 allegations of neglect including, o 20 confirmed o 92 unconfirmed o 1 inconclusive o 7 unfounded o 8 referred back to the facility for further investigation o 9 other o 21 pending outcome • 9 allegations of exploitation o 0 confirmed o 1 unconfirmed o 2 inconclusive o 2 referred back to the facility for further investigation o 1 other o 3 pending outcome

	According to a list provided by the facility, there were 79 other investigations of serious incidents not involving abuse, neglect, or exploitation. This included: • 15 serious injuries/determined cause, • 3 serious injuries from peer-to-peer aggression, • 4 serious injuries peer-to-peer aggression (offender) • 0 serious injury/undetermined cause • 9 sexual incidents, • 7 sexual incidents (offender) • 1 choking incident, • 4 unauthorized departure of campus • 4 suicide threats, • 6 encounters with law enforcement, and • 25 other. There were a total of 697 injuries reported between 12/1/13 and 5/31/14. These 697 injuries included 22 serious injuries resulting in fractures or sutures. This indicated an overall decrease in the number of injuries reported the previous six-month period (934). Injury trends were being generated by individual and were given to IDTs for planning. From all investigations since 12/1/13 reported by the facility, 22 investigations were selected for review. The 22 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 (14 cases). • Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS (8 cases). The parties agreed that there would be no monitoring for six 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 the 16 out of 16 provisions of section D that were reviewed. Some areas that need attention to ensure continued quality improvement and that substantial compliance is maintained with section D include: • The facility needs to work closely with DFPS to ensure that investigations are completed in a timely manner. • While the incident management and quality assurance departments were placing a greater focus on identifying trends of incidents and injuries, it was still not evident that IDTs were adept at revising supports and monitoring implementation following incidents. IDTs need additional training on using trend information to develop individualized supports to reduce the occurrence of incidents and injuries. IDTs should analyze data regarding incidents and injuries frequently to assess the effectiveness of supports.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee. The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as	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

#	Provision	Assessment of Status	Compliance
	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.		
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The 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) 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 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) 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	The parties agreed the monitoring team would complete a reduced review (smaller sample size) of this provision because the facility was in substantial compliance for more than three consecutive reviews. According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	immediately during pre-service and every 12 months thereafter after completing ABU0100 training. A sample of this form was reviewed for a random sample of 20 employees at the facility. 20 (100%) of 20 employees in the sample had a current signed acknowledgement form. A review of training curriculum provided to all employees at orientation, and annually thereafter, emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility reported that there were no cases where staff failed to report abuse or neglect as required. Investigation #43078760, however, involved a confirmed allegation of physical abuse reported to another staff person by the individual. The staff person was suspended following the investigation, in part, for failure to report the allegation. The facility had maintained substantial compliance with this provision.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The parties agreed the monitoring team would complete a reduced review (smaller sample size) of this provision because the facility was in substantial compliance for more than three consecutive reviews. A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. It was a clear and easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. A sample of 10 ISPs was reviewed for compliance with this provision. The sample ISPs were for Individual #884, Individual #386, Individual #261, Individual #211, Individual #80, Individual #816, Individual #521, and Individual #535. • Eight (100%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The new ISP format included a review of all incidents and allegations along with a summary of that review. This should be useful to teams in identifying trends and developing individual specific strategies to protect individuals from harm. In informal interviews with individuals during the review week, most individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility maintained substantial compliance with this provision.	
	(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 complete a reduced review (smaller sample size) of this provision because the facility was in substantial compliance for more than three consecutive reviews. A review was completed of the posting the facility used. It included a brief and easily understood statement of: • Individuals' rights, • Information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of a sample of living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There was a human rights officer at the facility. Information was posted around campus identifying the human rights officer with her name, picture, and contact information. The HRO was actively involved in educating individuals about their rights through the facility's self-advocacy group. The facility remained in substantial compliance with this provision item.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The parties agreed the monitoring team would complete a reduced review (smaller sample size) of this provision because the facility was in substantial compliance for more than three consecutive reviews. Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications. Based on a review of 14 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and/or OIG of the allegation in 14 (100%), when appropriate. OIG investigated seven cases in the sample and criminal activity was substantiated in one of seven (14%) cases. The facility remained in substantial compliance with this provision item.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The parties agreed the monitoring team would complete a reduced review (smaller sample size) of this provision because the facility was in substantial compliance for more than three consecutive reviews. The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • MSSLC Policy addressed this mandate by stating that any employee or individual who in good faith reports abuse, neglect, or exploitation shall not be subjected to retaliatory action by any employee of MSSLC. • Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this occurred. Based on a review of investigation records (Sample #D.1), there were no concerns related to potential retaliation for reporting. The facility maintained substantial compliance with this item.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The 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
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities,	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

#	Provision	Assessment of Status	Compliance
	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 complete a reduced review (smaller sample size) of this provision because the facility was in substantial compliance for more than three consecutive reviews. Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. There was no indication that staff did not cooperate with any outside agency conducting investigations. The facility incident management coordinator reported good cooperation between the facility incident management staff and DFPS. DFPS investigators had been given office space at the facility to expedite the investigation process.	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 complete a reduced review (smaller sample size) of this provision because the facility was in substantial compliance for more than three consecutive reviews. Based on a review of the investigations completed by DFPS, the following was found: • Of the 14 investigations completed by DFPS (Sample #D.1), OIG investigated seven of the incidents. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility maintained substantial compliance with this provision.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. The MSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		(Sample #D.3): • There was no indication that evidence was not safeguarded during any of the investigations. Video surveillance was in place throughout MSSLC, and investigators were regularly using video footage as part of their investigation. The facility remained in substantial compliance with this item.	

	(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.
		  o Contact with the alleged victim occurred within 24 hours in seven of 14 (50%) investigations. Exceptions were DFPS cases #43082033, #43078760, #43049309, #43033066, #43032471, #43003741, and #42982738. For those investigations, documentation showed that some type of investigative activity took place within the first 24 hours in all cases (100%). This included gathering documentary evidence and making initial contact with the facility.
		• For investigations in sample #D.1, six of 14 (43%) were completed within 10 calendar days of the incident. Extensions were filed for eight investigations.
		  o OIG also completed an investigation for five of the seven cases that were not completed within 10 days.
		• All 14 (100%) resulted in a written report that included a summary of the investigation findings.
		• In 12 of 14 (86%) DFPS investigations reviewed in Sample #D.1, concerns or recommendations for corrective action were included. One 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 included appropriate recommendations for follow-up action to address the incident.
			Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility was in substantial compliance with the requirement of D3e.	
	(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.	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
	(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	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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	<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). • Metric 2.g.4: The facility Incident Management Review Team (IMRT) did not note any problems with any of the investigations in the sample. • Metric 2.g.5: The monitoring team did not identify problems with regard to sections D.3.e and/or D.3.f. Based on a review of the facility's IMRT data, for n/a (__%), 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 no cases in the sample to DFPS for reconsideration. For __ (n/a), 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 returned to DFPS when the facility did not agree with findings or had further concerns. The monitoring teams make no judgment regarding the adequacy of the DFPS supervisory process, and it has not been taken into consideration in assessing compliance for this subsection. 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, • 14 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 14 (100%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. <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. The facility was in substantial compliance with investigation review requirements.	

#	Provision	Assessment of Status	Compliance
	(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 complete a reduced review (smaller sample size) of this provision because the facility was in substantial compliance for more than three consecutive reviews. A uniform UIR was completed for 22 out of 22 (100%) unusual incidents reviewed. A statement regarding review, recommendations, and follow-up was included on the review form. The facility maintained substantial compliance with this item.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	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 facility continued to track follow-up to recommendations in the daily IMRT meeting. Documentation of follow-up to recommendations was included in the investigation file. 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 six cases: • Five DFPS cases: #43078760, #43066671, #43009426, ##43025645, #43033066; and • Two facility investigations: UIR #3136 and UIR #3074 Metric 3.i.3: For four out of four (100%) of the DFPS investigations (DFPS cases #43078760, #43066671, #43009426, and #43033066) reviewed and one of one (100%) facility investigation (UIR#3136) in which disciplinary action was warranted, 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 three of the investigations reviewed (100%), prompt and thorough programmatic action had been taken and documented when recommended by DFPS or the facility investigator. DFPS case #43009426, DFPS#43025645, UIR#3074 documented that recommendations were addressed by the facility. Metric 3.i.5: The IMC reported that the facility had begun tracking recommendations to ensure that the expected outcome had been achieved as a result of the implementation of	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		the programmatic and/or disciplinary action. The facility had created a 30-45 day follow-up log to further track implementation of IMRT recommendations.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team. The facility maintained substantial compliance with this item.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to 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. The IMC reported that he reviewed data monthly and quarterly and made recommendations to address trends based on data analysis. Additionally, • The IMC participated in monthly PET II meetings by reviewing protection from harm monitoring tools and monthly trend reports for each residential unit. • Monthly trend reports were shared with unit administrators and QIDPs. • The IMC participated in QA/QI Council meetings to review quarterly trend reports and analysis for unusual incidents, abuse, neglect, and exploitation, and injuries. • When appropriate, workgroups were appointed to develop CAPS for identified trends.	Substantial Compliance

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		• Data were provided to ISP facilitators for review at annual IDT meetings prior to the meeting. 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 (CAPs) were typically developed. Metric 4.8: Corrective action plans were developed both for specific individuals and at a systemic level. For example, a QA critical meeting was held and a CAP was written to address a second allegation of abuse resulting in a serious injury for Individual #133. The facility developed a CAP to address breaches in supervision when a trend was identified across all investigations. Metric 4.9: The trend reports and minutes showed that corrective action plans were implemented and tracked to completion. The IMRT was responsible for tracking implementation of corrective action plans. The QA/QI committee further reviewed implementation. Metric 4.10: The trend reports/minutes reviewed, as appropriate, the effectiveness of previous corrective actions. Metric 4.11: Action plans included in the monthly trend report 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 the action plans reviewed the plan had been timely and thoroughly implemented. Metric 4.13: For action plans reviewed, there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan. This was a new process for the facility. The IMC was working with the unit directors and Assistant QIDP Director to ensure that actions were monitored for effectiveness. The facility was in substantial compliance with D4.	
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 complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews.	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.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of employees confirmed that their background checks were completed. Background checks were conducted on new employees prior to orientation and completed annually for all employees. Current employees were subject to fingerprint checks annually. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. According to information provided to the monitoring team, for FY14, criminal background checks were submitted for 785 applicants. There were 42 applicants who failed the background check in the hiring process and therefore was not hired. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self-report all criminal offenses. The facility remained in substantial compliance with this provision item.	

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS policy #003.1: Quality Enhancement, dated 1/26/12, updated 5/22/13 with new DADS administrative staff names o MSSLC facility-specific policies (no changes since last review): • Quality Assurance Adm-37, updated 6/6/14, to add QA Plan as an official appendix • Participating in PIT Monthly Meeting CC-42, updated 3/19/14 • PET Monthly Meeting CC-36, 4/1/13 • QAQI Council, 11/22/11 o MSSLC organizational chart, 5/12/14 o MSSLC policy lists, May 2014 o List of typical meetings that occurred at MSSLC, undated but likely May 2014 o MSSLC Self-Assessment, 5/9/14 o MSSLC Action Plans, 5/1/14 o MSSLC Provision Action Information, 5/19/14 o MSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 6/2/14 o MSSLC DADS regulatory review reports, 11/27/13-4/28/14 o MSSLC data listing/inventory, hard copy, 6/5/14 o MSSLC QA plan narrative, 6/6/14 o MSSLC QA plan matrix, 6/6/14 (combined into one document with inventory) o List of all QA department staff and their responsibilities, undated, likely May 2014 o MSSLC QA department meeting notes, bi-monthly, January 2014 and March 2014 o Set of blank tools used by QA department staff (1 tool), revised 2/1/14 o Sets of completed tools used by QA department staff (14), April 2014 o Standard trend analysis reports for four areas, for two quarters o Sets of other data: QAD LOS checks, FSPI, external medical o Monthly QAD-SAC-1:1 meetings minutes, called facility status reports, done at PET meetings, March 2014 and April 2014 o Unit PIT meetings, minutes and various handouts, monthly, new, April 2014 meetings of March 2014 data o PET II, III, and IV meetings, minutes and handouts, December 2013-April 2014 • PET II meeting handouts for 6/5/14 o MSSLC QA Reports, semi-monthly, December 2013 to June 2014 (12) o QAQI Council minutes, semi-monthly, December 2013 to June 2014 (6 months, 12 meetings) • Handouts and agenda for meeting during onsite review, 6/5/14 o PIT, PET, work group reports (work groups attached to QA reports) o MSSLC Corrective Action Plan documents

	• Blank CAP implementation form, 5/11/14 • MSSLC CAP tracking log, includes open (10) and all closed CAPs, 6/5/14 • Packets of information for the four CAPs that were developed since the last review, of these four, three remain open and one was closed out • Packets of information for two of the old format CAPs <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 <u>Observations Conducted</u>: o Unit morning meetings: Longhorn, Barnett, Whiterock o PET II monthly meeting, 6/5/14 o QAQI Council meeting, 6/5/14 o Executive management, 6/3/14
	Facility Self-Assessment The QA director improved the section E self-assessment in many ways. First, it lined up with what the monitoring team looks at more so than in previous self-assessments. Further, the QA director's results section accurately described many of the problems that were also observed by the monitoring team. Given that this report has alpha-numerically labeled the metrics, this should provide further guidance to the QA director for her next self-assessment. That is, the QA director could use these metrics in her own self-assessment. If so, however, she should be sure to read all of the detail provided within the report for each metric because there is important supplemental information provided. The facility self-rated itself as being in substantial compliance with E3 and in noncompliance with sections E1, E2, E4, and E5. The monitoring team agreed with the E3 self-rating, but also found E4 to be in substantial compliance. The difference was due to some documentation changes that the QA director made during the month between submission of the self-assessment and the onsite review.
	Summary of Monitor's Assessment: During this review period, the QA program at MSSLC made more progress than ever before, including achieving substantial compliance with sections E3 and E4. Numerous aspects of the program were improved, revised, or created. Although there was not yet a complete and adequate data list inventory, there was progress due to efforts by the QA director in working directly with department and section leaders. The data list inventory was 36 pages long and contained 28 topic areas (eight were not Settlement Agreement related).

	Of the 16 inventories, 16 (100%) included data that could be used to identify trends as required in the wording of section E1; 10 (63%) included a wide range of data; 16 (100%) included what appeared to be key indicators; 0 (0%) described the data being collected (most labeled the data item, but did not describe what data were being collected); and 12 (75%) included a self-monitoring tool. None (0%) of the items were categorized as a process or an outcome indicator. MSSLC did not have a separate QA plan matrix. Instead, double-asterisks were placed on data inventory items to indicate that these were matrix items. This was one way to ensure that all items in the matrix were in the inventory. QA plan matrix items, however, should include information regarding how the data for these items were to be collected, reviewed, and managed, such as frequency of data collection/summary, person responsible for review, and how data were to be presented. The items in the inventory lined up with what was in the matrix, but did not line up with what was in the QA report and what was presented to QAQI Council. MSSLC re-initiated unit level PIT monthly data review meetings, continued with monthly PET groups, and held occasional QA critical incident meetings. Various work groups existed, but were not yet incorporated within the QA program. Data for 20 of the 20 (100%) sections of the Settlement Agreement were summarized, however, few sections analyzed data across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals. A QA report was issued twice each month. Of the 20 sections of the Settlement Agreement, 20 (100%) appeared in a QA report at least once each quarter in the last six months. The reports did not contain any type of narrative analysis (most had either no narrative or a narrative that described the data). QAQI Council met twice each month. The most recent minutes (May 2014) contained more detail about items discussed and actions to be taken than the minutes from the other months. Continued work was done to improve the CAPs system, including the creation, management, and reporting of CAPs. In general, the QA director totally revised the CAPs system. There were 10 active CAPs, though three were in the new format. Based upon a review of these new format CAPs, the monitoring team found compliance with sections E3 and E4. Continued work, however, was needed to define criteria for achieving a CAP (E2) and managing revisions when needed (E5).

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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.	During this review period, the QA program at MSSLC made more progress than ever before. Numerous aspects of the program were improved, revised, or created. The QA director, Kim Kirgan, focused upon improving the QA program and the results were evident. All of the members of the QA department remained the same, which helped to support consistency and progress. A QA staff meeting was bi-monthly. Relevant topics were discussed. Since the last review, three of the homes on campus were certified as meeting ICF requirements, and there were no open ICF regulatory items across the entire campus at the time of the onsite review. Facility management, QA department staff, and unit directors were very proud of these accomplishments. <u>Policies</u> a. 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, updated 5/22/13. The monitoring team's comments on the state policy are in previous monitoring reports and are not repeated here. b. There were not facility policies that adequately supported the state policy for quality assurance. Even so, progress had been made. The facility-specific policy Quality Assurance: Administrative #37 was merely a repeat of the state policy and, therefore, by itself, would be insufficient. However, a recent update of this policy, approved by QAQI Council during the onsite review, made the QA plan narrative an official addendum to this policy. The QA plan narrative, however, was not yet adequate (see below). In addition, there were three other facility-specific policies. These addressed the PIT, PET, and QAQI Council meetings. The QA director should review these for accuracy and updating, if needed. <u>Quality Assurance Data List/Inventory</u> c. There was not yet a complete and adequate data list inventory at the facility. Even so, there was progress due to efforts by the QA director in working directly with department and section leaders. The data list inventory was 36 pages long and contained 28 topic areas (eight were not Settlement Agreement related). Sections C and K; sections G, H, and L; and sections O, P, and R were combined into single inventories. The monitoring team was easily able to discern the C items from the K items and treated this as two inventories for the purpose of this review. 20 of the 20 provisions of the Settlement Agreement (100%) were included in these 16 inventories. Of the 16 inventories, 16 (100%) included data that could be used to identify trends as required in the wording of section E1 (but weren't being used in this way); 10 (63%)	Noncompliance

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		included a wide range of data; 16 (100%) included what appeared to be key indicators; 0 (0%) described the data being collected (most labeled the data item, but did not describe what data were being collected); and 12 (75%) included a self-monitoring tool. None (0%) of the items were categorized as a process or an outcome indicator. The section N inventory included a self-monitoring tool and then listed the data items that were part of this tool. This was an excellent way for the reader to understand the content of the self-monitoring tool. If this was the case for any of the other inventories that included a self-monitoring tool (which was probably the case), it should be explicitly noted. A new data item that unique to MSSLC, criminal activity, was added to the section E inventory. The inventories contained four columns. The first was to indicate the source of the data. Some were correctly completed (e.g., preventive service database), but others were not (e.g., PDF, excel spreadsheet). The other three columns were to indicate if the data item was to be presented at monthly PET meetings, at the QAQI Council (and in the QA report), and at the next QAQI Council meeting (the monitoring team did not understand the difference between these last two columns). These columns were not yet completed for all of the inventories. Inventories were being reviewed once per quarter at the PET meetings, however, given the many other activities that occurred at this meeting, not much attention was actually given to the content of the inventories presented. Therefore, the QA director had a reasonable plan, which was to, over the next two months, review the inventories with each department head during a specially-arranged meeting. The QA director's goals included to ensure that no important items were missing from the inventory, that process and outcome indicators were included, and that data were being collected as per the wording of section E1. This will increase the likelihood of the inventories meeting criterion at the time of the next review. d. The data list inventory was current. 16 of the 16 lists (100%) were updated within the past six months. Each inventory had its own date of update. <u>Quality Assurance Plan Narrative</u> e. The QA plan narrative was not current, complete, and adequate. Good progress was made, especially regarding the CAPs program. The section regarding key indicators needed to be re-done.	

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		QA Plan Matrix The QA plan matrix should contain the data from the data list inventory that are to be submitted to the QA department; most (but not necessary all) of these data are then included in the QA reports and presented to the QAQI Council. • MSSLC did not have a separate QA plan matrix. Instead, double-asterisks were placed on data inventory items to indicate that these were matrix items. This was one way to ensure that all items in the matrix were in the inventory. • QA plan matrix items, however, should include information regarding how the data for these items are to be collected, reviewed, and managed, such as frequency of data collection/summary, person responsible for review, and how data are to be presented. This was not being done in the MSSLC matrix. • The section E self-assessment, page 39, noted that the QA director was aware of this need and was planning to eventually have a separate QA matrix document that contained this type of information. o Given the way the database was currently being used, the QA director could simply add columns to a single database and fill in these matrix-related columns only for those items designated to be in the matrix. An electronic or paper presentation that included these columns could be accessed/presented only when the purpose was to review the matrix. The items in the QA matrix should line up with the data list inventory, content of the QAD-SAC 1:1 meetings, content of the QA reports, and presentation at QAQI Council. At MSSLC, the items double-asterisked as QA matrix items: • did line up with what was in the data list inventory (because they were part of the same database). • were not reviewed during QAD-SAC meetings (because these meetings were not occurring). • did not line up with what was in the QA reports and presented at QAQI Council meetings. o Evaluating this correspondence was not being done, but should be. f. There were items in the QA plan matrix for 20 of the 20 sections (100%). The items represented a set of key indicators for 20 of the 20 (100%). g. Of the 20, both process and outcome indicators were identified for 0 of the 20 (0%) in the QA matrix. h. Of the 20, in 20 (100%), 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;	

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		work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports." o The QA director should describe, for each section (perhaps in the QA matrix and/or in the 1:1 meeting minutes) how data were being collected and presented to identify trends across the variables described in the wording of E1. i. 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. • It should also separate out the self-monitoring tool as a whole from its component parts. • This was done in 12 (75%) of the matrix/inventories. j. All data that QA staff members collected were listed in the matrix. There was one tool. k. All of the items in the QA matrix also appeared in the QA data list inventory. QA Plan Implementation When the QA matrix includes detail regarding implementation, the following metrics will be assessed: l. Submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., at least once each quarter). m. Reviewed or analyzed by the QA department and/or the department section leader. n. Conducted and implemented as per the schedule. o. Received QA department assistance in analysis of data, or if there was no assistance provided, there was documentation that it was not needed. Self-Monitoring Tools The QA department and section leaders were going to be working on the status of what were called self-monitoring tools for each section. That is, they were going to determine if a separate self-monitoring tool was necessary or if the set of data being collected by the department was covering all of the aspects of department services that needed to be self-monitored. As a result, the monitoring team did not attempt to quantify the following metrics for this report p. 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.	

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		q. 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. r. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. s. 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.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	Progress was seen at MSSLC regarding the gathering, organization, and analysis of data. In this section (E2,) the monitoring team's findings are based upon the data that were included in the QAD-SAC 1:1 meetings documentation (if any), in QA reports, and in QAQI Council meeting minutes. Based upon the QA reports: a. Data from the QA plan matrix for 20 of the 20 (100%) sections of the Settlement Agreement were summarized (though as noted in E1, the data in the QA report did not include all of the items identified as QA matrix items; this should be corrected). • Few sections, however, analyzed data across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals. <u>Monthly QAD-SAC meeting with discipline departments</u> Meetings between the QAD-SAC and discipline department section leaders were not occurring at MSSLC. The QAD planned to begin holding these periodically, if not monthly. The purpose of these meetings is to review the status of various aspects of quality assurance and quality improvement activities. The QAD had attempted to accomplish this during the PET meetings, but was unable to accomplish a meaningful and sufficient review of these QA activities. She kept a checklist of about a half-dozen items for March 2014 and April 2014, but the information in these checklists was minimal. Going forward, at a minimum, each of the five bulleted items in metric b. below should be explicitly addressed at least once each quarter in this type of forum. b. Since the last onsite review, a meeting occurred at least twice for 0 of the 20 (0%) sampled sections of the Settlement Agreement. • 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.	Noncompliance

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		Given there were no QAD-SAC 1:1 meetings, the following three metrics were not rated: c. Since the last onsite review, during n.a. of the n.a. (--%) meetings, data were available to facilitate department/discipline analysis of data. d. Since the last onsite review, during n.a. of the n.a. (--%) meetings, data were reviewed and analyzed. For the purposes of this metric, the monitoring team rates this as acceptable if there was review and discussion of data. e. Since the last onsite review, during n.a. of the n.a. (--%) 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. <u>QA Report</u> The MSSLC QA report was assembled prior to each QAQI Council meeting. Thus, there were two QA reports each month. The monitoring team reviewed the 12 QA reports for December 2013 through May 2014. The information in the QA report was what was presented at QAQI Council. f. 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%). g. Of the 20 sections of the Settlement Agreement, 20 (100%) appeared in a QA report at least once each quarter in the last six months. h. Of the 20 sections of the Settlement Agreement that were presented quarterly, 0 (0%) contained all of the components listed below. • 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 - Six sections reported use of a self-monitoring tool (C, D, I, J, S, M). The others did not. For some, data were presented by the above areas (section D) or for some portion of these area. • 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 - 20 of the 20 sections presented a variety of other key indicators and important data; this was good to see. There was, however, a range from many items to just a few. In some cases, it seemed that the many data items were the components of the self-monitoring tool. The QAD and section lead should tease this out so that it is clear. Section N did this in	

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		their data inventory. - An area for improvement is to show data and trends across the variables listed in E1 (or indicate clearly a rationale for not doing so). This was done somewhat in about a quarter of the sections. The variables presented were, for the most part, by unit or by discipline department/provider. - The section E report should eventually include data on QA activities (e.g., from the QAD-SAC 1:1 meetings). - Data were probably available for 12 months or more for many indicators, however, many reports only showed data for the current month or current quarter. • Narrative analysis - There should be an analysis of the causes of the problems, not just a description of their occurrence. Section D contained relatively good narrative analysis. Other sections had some narrative analysis, but primarily only described the data (e.g., J, K, M, N, Q, S). - The QA director and SAC might include a template for the section leader that prompts one paragraph for a summary of the data and a separate paragraph for the analysis of the data. - The content/data items of the QA report did not line up with what was in the data list inventories or QA matrix. <u>QAQI Council</u> This meeting plays an important role in the QA program. The monitoring team attended a meeting during the onsite review and read the minutes of the monthly QAQI Council meetings from January 2014 through May 2014 (10 meetings). i. There was an adequate description of the QAQI Council in the QA plan narrative. j. Since the last onsite review, the QAQI Council did meet at least once each month. The QAQI Council at MSSLC met twice per month. k. Minutes from all (100%) QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics. l. Minutes from all (100%) QAQI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. m. Minutes (and attachments/handouts) from all 10 of the QAQI Council meetings since the last review documented that: (a) data from the QA plan matrix (indicators, self-monitoring) were presented in	

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		10 (100%), (b) the data presented were trended over time in 10 (100%), and (c) comments and interpretation/analysis of data were presented in 0 of the presentations (0%). It is possible that the minutes did not accurately reflect the discussion that occurred during the meeting. The minutes from the meetings in May 2014 were the most detailed of the set of minutes. n. Minutes from 2 of the 10 (20%) 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. These were the two most recent (May 2014) minutes. More detail was included regarding discussion and actions to be taken. In addition to QAD-SAC 1:1 meetings, QA reports, and QAQI Council, the monitoring team wishes to mention four other QA-related activities at MSSLC: • The facility re-instated the unit PIT meetings. These were monthly data reviews led by each of the unit directors. This was re-instated in April 2014. The unit directors reported that they re-designed the PIT meetings in order to make them more useful to the unit staff than were the PIT meetings that were being held a year or so ago. • Monthly PET meetings continued to be held. There were three groups (i.e., three PETs) and during their meetings, each section leader in that group presented his or her data for the previous month. The PETs set the occasion for monthly reviews and presentations of data (whereas QAQI Council and QA reports were quarterly). • The QA director held occasional critical incident meetings if she determined that additional actions were required by the QA program and facility to follow-up to an incident. This occurred twice since the last review. In both cases, a CAP resulted. • Many of the various work groups at MSSLC were not tied to the QA program, but should be. <u>Corrective Actions</u> Work was done to improve the CAPs system, including the creation, management, and reporting of CAPs. The QA director totally revised the CAPs system. The monitoring team reviewed a number of CAP-related documents. The number and breadth evidenced the efforts put into the CAPs program. • The CAPs program was described in much more detail in the QA plan narrative. • There was a CAP implementation form for each new CAP.	

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		• There was a CAP tracking log with detail of the status of each CAP. • General data about CAPs and the status of CAPs were presented to QAQI Council. • The QAD kept a log of open CAPs. • The QAD kept a log of closed CAPs. There were 10 open CAPs. Three of these were under the new format of CAPs. The other seven were created and documented under the old format. The QAD planned to close out these seven in the next month, or she was going to put them into the new format. One of the closed CAPs was a new format CAP. The monitoring team used the four new format CAPs (3 open, 1 closed) for this review. Again, the monitoring team reviewed 3 of the 10 open CAPs and 1 of the more recently closed CAPs for the purposes of the following metrics, through E5. o. An adequate written description did exist that indicated how CAPs were generated, however, more detail should be provided regarding the criteria for the development of a CAP. Including examples of actions that would be considered CAPs and examples of actions that would not be considered CAP would help the QA department and senior management in determining when it was appropriate to create a CAP. p. When considering sample of CAPs, 4 of 4 open and closed CAPs were chosen following the written description, policy, or procedure (100%). • That being said, the CAPs program was not being implemented/used by most of the facility departments. In other words, the four CAPs were chosen as per the written description, but there were many other aspects of service provision improvement at MSSLC for which a CAP would have been appropriate and which likely would have met the criteria for a CAP to be created. q. Of the 4 CAPs reviewed by the monitoring team, 4 (100%) appeared to appropriately address the specific problem for which they were created. • There was, however, no criterion to judge when/if the overall CAP was being met. That is, none (0%) had a specific criterion attached to the overall CAP. The monitoring team suggests that the QA director consider each CAP to be an objective and, therefore, each would contain an observable measurable action (think of actions as you would an observable behavior in a SAP or PBSP), and an observable measurable outcome with a criterion. • 0 of the 4 (0%) CAPs looked at assessing outcomes to ensure that the problem originally identified was remedied or reduced. None reported on	

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		the status of the original problem. Based on these 4 CAPs: r. 4 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. The CAPs contained a large number and wide variety of actions. The number ranged from 7 to 22. s. 4 (100%) included the anticipated outcome of each action step. • 0 of 4 (0%) included specific criteria to judge if the outcome of each action step was met. Most were not written in a behavioral objective type format with the observable behavior and observable criteria clearly described. t. 4 of the 4 CAPs (100%) included the job title and name of the person(s) responsible. u. 4 of the 4 (100%) included the time frame in which each action step must occur (i.e., a due date).	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the 4 open/new CAPs, which represented 36% of the total: a. 4 (100%) included documentation about how the CAP was disseminated b. 4 (100%) included documentation of when each CAP was disseminated, and c. 4 (100%) included documentation of to whom it was disseminated, including the names and titles of the specific persons responsible.	Substantial Compliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	a. Based on a sample of 3 open CAPs and 1 closed CAP, 4 (100%) were implemented fully and 4 (100%) were implemented in a timely manner. • The QAD included a monthly report of the status of the fully and timely implementation of the action steps in the CAP. b. There was an adequate system for tracking the status of CAPs. Of the 3 open CAPs being tracked by the facility, 3 (100%) indicated the status of the CAP. • There was running commentary about status, actions, data, anticipated closure, etc. c. The facility QA director did maintain summary information/data regarding CAPs and their status (regarding open or closed, and status of action steps) that was updated within the month prior to the onsite review. • The monitoring team recommends that the QAD begin to maintain and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		report data on the number of CAPs and their status, to trend/graph these data across months, and to include these data within her section E data inventory and QA report. d. The QA director or section leader did present this information to QAQI Council at least quarterly.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The monitoring team will assess these metrics at the next review. a. For n.a. out of n.a. CAPs (--%), documentation showed review of their effectiveness (i.e., outcomes), and for n/a out of n/a CAPs (--%), documentation showed review of their timely completion. b. Of the n.a. CAPs that appeared to need modification, n.a. (--%) were modified. c. Based on a sample of n.a. completed CAPs and n.a. in process CAPs, n.a. (--%) were discussed at QAQI Council. d. For n.a. out of n/a (--%) modified CAPs, evidence was present to show timely implementation. e. For n.a. out of n/a (--%) modified CAPs, evidence was present to show full implementation.	Noncompliance

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #004.2: 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 Section F PET Monthly Worksheet November 2013-March 2014 o List of all QIDPs and assigned caseload o A list of QIDPs deemed competent in meeting facilitation o Tool used to assess competency with facilitation skills o QIDP Training Curriculum 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 and date ISP was filed. o A list of ISPs filed late o Draft ISPs and Assessments for Individual #519 and Individual #557 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #113, Individual #884, Individual #386, Individual #261, Individual #211, Individual #80, Individual #816, Individual #521, and Individual #535. Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; o Charlotte M. Kimmel, Director of Behavioral Services o Patrick Samuels, Incident Management Coordinator o Ramona Echols, QIDP Director o Craig Burgess, Assistant QIDP Director o Don Morton, Assistant Director of Programs Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 6/2/14 and 6/3/14 o Longhorn Morning Unit Meeting 6/4/14 o PET II Meeting for sections C, D, K, and J o ISP preparation meeting for Individual #539 o Annual IDT Meeting for Individual #557 and Individual #519

	○ ISPA for Individual #451 regarding restraints
	Facility Self-Assessment: The self-assessment was updated on 5/13/14 with recent activities and assessment outcomes. For each provision, the facility had identified: (1) activities engaged in to conduct the self-assessment, (2) the results of the self-assessment, and (3) a self-rating. The QIDP Director was responsible for the section F self-assessment. The current self-assessment reported on the activities engaged in to conduct the self-assessment, provided the results of the self-assessment, and provided a self-rating for each provision item. MSSLC used the statewide section F monitoring tool to assess compliance with section F. Additionally, the facility had a number of other tools to assess compliance with specific provisions including: • QIDP Monthly Review Monitoring Form • QIDP Review of Individual Notebooks • Pre-ISP Monitoring Tool • Individual Support Plan Meeting Monitoring Checklist The facility continued 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. Their own data, however, often did not support the facility's justification for noncompliance ratings in regards to compliance with the requirements of the provision. This suggested that the facility was not confident in the quality of data gathered. The facility needs to re-evaluate methods for assessing compliance to determine if assessment methods result in an accurate assessment of compliance. 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. The monitoring team agreed with the overall assessment of noncompliance for each provision item.
	Summary of Monitor's Assessment The facility had made little progress in developing an adequate IDT process for developing, monitoring, and revising treatments, services, and supports for each individual. Recent turnover in the QIDP department had impacted progress made during previous visits. Six new QIDPs had been hired since February 2014. Two of the new QIDPs had not yet completed training. The facility implemented a section F PET. The QIDP Director met monthly with the QA Director to review progress with the requirements of the Settlement Agreement. An ISP workgroup was recently established consisting of the QIDP Educator, QIDP Director, Assistant QIDP Director, QA staff, and representatives from the medical, behavioral health, and habilitation therapies department. The group was developed to review

	completed ISPs for quality of input by each discipline. Ongoing training was being provided to QIDPs and staff designated to implement support plans. Two annual ISP meetings were observed during the monitoring visit. Both IDTs were struggling with the statewide ISP planning process and what the resulting outcome should be. Both meetings observed were lengthy and did not result in a plan that would ensure meaningful programming and supports. The IDTs did not develop outcomes that would build on what the individuals were currently doing to offer new experiences or opportunities to learn new skills based on identified preferences. It was not clear that supports developed by the IDT were either meaningful or functional for the individual. The facility did not have an adequate system in place to ensure that plans were implemented and supports were monitored for efficacy. At ISP meetings observed, the IDT was unable to determine whether or not progress had been made towards outcomes or whether supports were effective, in some cases. Some data were presented regarding supports in place, however, team members were not sure what the data represented or specifically what progress had been made. Consequently, few changes were made to supports and services even when progress was not evident. IDTs need additional training on how to develop integrated action plans based on assessment recommendations that incorporate the individual's preferences. IDTs need guidance on setting priorities for training and developing measurable objectives with clear directions for staff who implement plans. 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 continue 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 and one pre-ISP meetings. The ISP facilitator facilitated the annual IDT meetings. 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, the CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, QIDP monthly reviews, the individual's daily schedule, and ISP Preparation Meeting documentation. A sample was requested of the most recently developed ISPs from each residence, and eight were submitted for review. A variety of QIDPs and IDTs responsible for the development of the plans were sampled. The QIDP Director confirmed that QIDPs facilitated the teams, including team meetings. Observations of team meetings and reviews of ISPs also illustrated that the QIDP/ISP Facilitator was the team leader and responsible for ensuring team participation. The QIDP Director oversaw the QIDP Department. The facility had 23 QIDPs with two vacant QIDP positions. There were three ISP facilitators responsible for facilitating the annual IDT meetings. The facility had recently hired a QIDP assistant director. The facility used the Q Construction Assessment Tool to assess QIDPs for competency in facilitation. According to documentation submitted by the facility (document V.9), 22 of the QIDPs and the three ISP facilitators had been deemed competent in facilitation skills. One QIDP was newly hired and still completing training. 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 ISP facilitators used this template to draft portions of the ISP prior to the meeting. The facilitators came to the meeting prepared with a draft Integrated Risk Rating Form and a draft ISP format. The draft IRRF was not distributed to IDT members during Individual #519's annual IDT meeting. The nurse case manager read data entered into her draft for each risk category. This was a barrier to integrated discussion at the meeting.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Based on observations of meetings held the week of the onsite review and review of related documentation, facilitation of team meetings was continuing to improve. However, there were still a number of barriers to ensuring that the team developed a comprehensive ISP that integrated all needed services and supports. Barriers included, but were not limited to: • Assessments were still not consistently completed and available to IDT members prior to annual IDT meetings. • It was not evident that all team members were either present at meetings, or, if not physically present, had the opportunity to provide adequate input prior to the meeting. • Implementation and monitoring of supports was inconsistent. Team members were unable to determine that status of outcomes implemented the previous year or identify barriers to achieving those outcomes. • QIDPs did not ensure that the IDT developed measurable, functional objectives to address prioritized needs. A sample of IDT attendance sheets was reviewed for presence of the QIDP at the annual IDT meeting. QIDPs were in attendance at six (75%) out of eight annual meetings in the sample reviewed. Signature sheets for Individual #211 and Individual #535 did not include the QIDP signature. QIDPs remained responsible for monitoring and revision of the ISP. As noted throughout this report, the monitoring team found that 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 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 QIDPs participate in ISP meetings. 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,	DADS Policy #004.2 described the Interdisciplinary Team (IDT) as including the	Noncompliance

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<tr><td></td><td>the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.</td><td>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 QIDP Director was tracking attendance by relevant IDT members monthly. The table below is a summary of data gathered by the facility in regards to attendance at annual ISP meetings for November 2013-April 2014.

<table>
<tr><th>Team member</th><th></th></tr>
<tr><td>Individual</td><td>91%</td></tr>
<tr><td>LAR</td><td>No data</td></tr>
<tr><td>Family/Advocate</td><td>No data</td></tr>
<tr><td>DSP</td><td>95%</td></tr>
<tr><td>QIDP</td><td>99.5%</td></tr>
<tr><td>Psychologist/BA</td><td>100%</td></tr>
<tr><td>RN</td><td>99,8%</td></tr>
<tr><td>Habilitation Therapy</td><td>99%</td></tr>
<tr><td>Dietician</td><td>87.5%</td></tr>
<tr><td>Primary Care Provider</td><td>100%</td></tr>
<tr><td>Psychiatrist</td><td>90.5%</td></tr>
<tr><td>Dental Services</td><td>82%</td></tr>
<tr><td>Pharmacy</td><td>100%</td></tr>
<tr><td>Vocational Services</td><td>99.8%</td></tr>
<tr><td>SAM/HIP</td><td>100%</td></tr>
<tr><td>LA</td><td>No data</td></tr>
</table>

Additional data provided by the psychiatry department revealed that the psychiatrist only attended 13% of the ISP meetings for individuals followed by psychiatry clinic between 12/3/13 and 5/29/14. The QIDP Director acknowledged that IDTs did not always correctly identify key team members that should be present at annual meetings. Psychiatry was rarely identified by the IDT as a key team member even when the individual received psychiatric services that significantly impacted all services and supports. In March 2014, the QIDP Director met with the medical director, psychiatry, and nutrition to revise the pre-ISP shell to assist IDTs in identifying team members required to attend annual ISP meetings.

Review of a sample of ISP attendance sheets revealed that there were key staff missing</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		who were identified as relevant participants in seven of eight (88%) of the annual meetings in the sample (i.e., full attendance by relevant participants occurred in 12% of the ISPs). The sample was Individual #535, Individual #261, Individual #80, Individual #521, Individual #816, Individual #211, Individual #884, and Individual #386. Individual #80's ISP was developed by an appropriately constituted IDT. Regarding those that were not: • Key team members not in attendance at Individual #521's annual ISP meeting included his LAR and day program staff. • Individual #881's OT and vocational staff were not present at his annual ISP meeting. • Vocational staff did not attend Individual #386's and Individual #261's ISP meetings. Vocational staff were identified as relevant team members at the pre-ISP meetings for both individuals. • Individual #211's and Individual #535's QIDP did not attend the annual meeting. • Individual #816's psychiatrist did not attend his annual ISP meeting. The IDT did not identify the need for participation by the psychiatrist, however, he received psychiatric services and an updated evaluation was not completed prior to his annual meeting. In zero of eight ISPs (0%), for any team members not physically present at the IDT meeting, was there evidence of their participation in the development of the ISP. 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. When team members cannot attend the meeting, the ISP should note efforts to get input from those team members prior to the annual meeting.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	DADS Policy #004.2 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. Annual ISP preparation meetings were held approximately 90 days prior to the annual ISP meetings. At the ISP preparation meeting, the IDT was to identify the assessments that were required for the annual ISP meeting. The state policy required that these assessments be completed and placed in the share drive for IDT review no later than 10 working days before the annual ISP meeting for review by all IDT members. The assessments were to be used by the QIDP to develop an ISP Guide prior to the ISP annual meeting. Two ISP preparation meetings were observed. The IDT completed a checklist	Noncompliance

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<tr><td></td><td></td><td>at both meetings indicating what assessments would need to be completed prior to the annual ISP meeting.

At both ISP meetings observed, the IDT did not have assessment information needed to develop or revise appropriate supports. For Individual #519, the team spent considerable time discussing behavior that resulted in numerous restrictions, incidents, and injuries. A functional assessment was not available to assist the team in developing effective supports. The behavioral health specialist had to leave the meeting to find behavioral data when team members disagreed on the status of his behavioral outcomes. Some team members expressed concern regarding insomnia. The team did not have reliable sleep data available to review. During Individual #557's risk discussion, the nurse noted that she had several incidents of vomiting during the past year. Specific data regarding the incidents were not available, thus, the team was unable to adequately address the effectiveness of her supports.

The facility was gathering data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of assessments for November 2013 through April 2014 indicated that there had been improvements in the number of assessments submitted prior to ISP planning meetings. The chart below shows overall assessment submission rates for that time period. (Discipline specific data were not provided by the QIDP department.)

<table>
<tr><th>Month</th><th>Late Assessments</th><th>Percentage Submitted On Time</th></tr>
<tr><td>November 2013</td><td>134/487</td><td>72%</td></tr>
<tr><td>December 2013</td><td>126/479</td><td>74%</td></tr>
<tr><td>January 2014</td><td>179/513</td><td>65%</td></tr>
<tr><td>February 2014</td><td>128/550</td><td>77%</td></tr>
<tr><td>March 2014</td><td>84/425</td><td>80%</td></tr>
<tr><td>April</td><td>65/448</td><td>85%</td></tr>
</table>

A review of a sample of ISPs developed in the last six months supported the facility's own finding that some assessments were not being submitted prior to annual ISP meetings in some cases.

In reviewing the ISPs for eight individuals, the teams for eight individuals (100%) had identified the comprehensive assessments necessary to identify the individuals' strengths, preferences, and needs, and/or had provided adequate justification for not requiring such assessments. The sample was Individual #535, Individual #261, Individual #80, Individual #521, Individual #884, Individual #816, Individual #211, and Individual #386.</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		The pre-ISP determination of assessments needed prior to the annual IDT meeting list was compared to assessments submitted. All requested assessments were completed 10 days prior to the annual ISP meeting for two (25%) of eight individuals (Individual #386 and Individual #211). • Individual #261 did not have an updated psychological or psychiatric assessments. • Individual #80's psychiatric, psychological, and audiology assessments were not updated prior to her annual IDT meeting. • Individual #535's medical assessment, FSA, and vocational assessment were not submitted 10 days prior to his annual ISP date for review by other team members. His psychological and audiology assessment were not updated prior to his annual IDT meeting. • Individual #521's psychological, psychiatric, and audiology assessments were not updated prior to her annual ISP meeting. • Individual #816's audiology, dental, and psychiatric assessments were not completed at least 10 days prior to his ISP for review by team members. His psychological assessment was not updated. • Individual #884's psychological assessment was not updated prior to his annual ISP meeting. In eight of eight (100%), the team considered what assessments the individual needed and would be relevant to the planning process. The team defined the assessments that were needed for the annual meeting during the ISP preparation meeting. In two of eight (25%), the team obtained the needed relevant assessments. Two of the individuals in the sample had <u>all</u> assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. Assessments from various disciplines were reviewed to determine if the assessments were submitted and if they included recommendations that were adequate for planning. For all disciplines, the quality of assessments had improved. Assessments generally provided information/recommendations that could guide the IDT to support the individual and develop a comprehensive plan to help the individual learn or develop a skill, achieve an outcome, or address a medical or behavioral issue. Findings were: <u>Behavioral Health Services</u> The quality of functional assessments, full psychological assessments, and annual psychological updates was excellent. Functional assessments were completed and timely, however, for only 26% of individuals with PBSPs. Similarly, only 57% of	

#	Provision	Assessment of Status	Compliance
		individuals had a full psychological assessment, and 58% of individuals had an annual update. There was some evidence that functional assessments were redone in response an increase in problem behavior. OT/PT/Communication All assessments reviewed included a description of the individual's strengths and preferences. The therapists typically provided a suggestion for a SAP, but there was limited evidence that they participated in the development, training, or review of these. The clinicians made recommendations for direct therapy for traditional speech therapy related to articulation or language disorders, though the assessment of and provision of AAC was extremely limited. Psychiatry The psychiatry department continued to track recommendations submitted via the IRRF process, and reported that 61% of these were delinquent. It is imperative that psychiatry is an active part of the ISP process inclusive of timely submission of IRRF and attending ISP meetings. Nursing The majority of the assessments reviewed identified the individual's strengths, preferences and needs. For example, Individual #628's record contained information associated with his level of risk for aspiration when considering administration of his medication. His preference was with a tongue blade, of which the IDT was in agreement. For over half of the reviewed assessments, the recommendations section included recommendations to sufficiently guide the IDT to support the individual and develop a plan of care to help address a health or behavioral issue. Individual #188 was a positive example of recommendations that included the necessary specificity to guide the IDT to support the individual and to help the individual address her health issues. 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 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.	
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	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. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	individual.	In zero of two (0%) ISP meetings observed, recommendations from assessments were used to develop plans that would provide a broader range of experiences and lead to the development of new skills. It was not clear in either meeting how the IDT established priorities for training. Outcomes were based on activities that the individuals already had an opportunity to participate in without consideration of potential new opportunities for growth. For example, • At Individual #557's meeting, the team acknowledged that her current home did not provide her with a peer group that offered her opportunities for meaningful social interaction. The team stopped short of developing new supports that would provide additional opportunities to develop new relationships. • At Individual #519's meeting, the team indicated that work was an important part of his day. Vocational staff reported that attendance at the sheltered workshop had been sporadic throughout the previous year. He had not completed his outcome to work for 30 minutes at a time. The team agreed to lower criteria for his outcome to 15 minutes without addressing barriers to completing his outcome. It was not clear that an adequate vocational assessment had been completed prior to the ISP meeting. The IDT did not consider vocational outcomes that would offer him further opportunities to develop new work skills based on his preferences. The adequacy of integration of recommendations into the ISP for specific disciplines is discussed in detail in other sections of this report and some comments are below. Recommendations from assessments were consistently used to develop PBSPs plans for individuals. For example functional assessments were consistently used to develop PBSPs to address behavioral issues. On the other hand, only 59% of SAPs were based on clear needs identified in assessments. At least half of recent nursing assessments reviewed contained statements that were used to develop appropriate protections, services, and/or supports for the individual. For example, Individual #65's contained statements regarding his immunity/immunization/vaccination needs. There were measurable goals established for direct therapies across OT, PT, and speech, but these were not included in the ISP. It was noted during an ISP for Individual #557 that equipment listed on the PNMP had not been in use for over a year. No one at the meeting could state whether they were still required. It was of concern that this problem had not been identified during the annual assessment or PNMP monitoring that should have occurred over the previous 12 months.	

#	Provision	Assessment of Status	Compliance
		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.	
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).	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 a consensus opinion by team members from various disciplines. Any barriers to community placement were to be addressed in the ISP. See section T regarding the quality of discipline specific determinations. None (0%) of the individuals in the sample were offered a range of opportunities to participate in meaningful activities in the community. None (0%) of the individuals in the sample had adequate access to the use of community services and community supports (e.g., hair salons, gyms, banks, churches, pharmacies). None (0%) of the ISPs in the sample indicated that the individual was adequately integrated into the community (e.g., regularly participated in activities in the community and engaged with others in the community, had memberships, hobbies, and interests, works/volunteers, or contributed to the community in some way). The facility continued to provide some day programming opportunities in the community at the ACE center. ISPs did not include formal training to be implemented in the community. General outcomes were written to attend activities at community sites without describing what training would occur while there. At both IDT meetings observed, the IDT engaged in discussion regarding community living options. The IDTs developed outcomes for further exposure to living options through opportunities to visit in the community, however, the IDT did not consider outcomes that would encourage community integration for further exposure to new things in the community. Neither IDT developed measurable outcomes to address barriers to community placement. Six ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #816, Individual #80, Individual #535, Individual #521, Individual #385, and Individual #466. None (0%) of the ISPs included meaningful training opportunities in the community. Community based outcomes for all 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 #816 had community based outcomes "will have the opportunity to	Noncompliance

#	Provision	Assessment of Status	Compliance
		utilize community services and engage in leisure activities in the community" and "will have the opportunity to dine at preferred restaurants and shops monthly." None of his outcomes provided support for him to learn new skills in the community. There was no focus on providing supported employment or volunteer opportunities in the community for individuals at the facility. None (0%) 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 discussion of support needs in relation to preferences. The teams reviewed the list of preferences developed during the pre-ISP meeting and attempted to develop plans to include the individual's preferences. Teams were not adept at using preferences to build on new training opportunities for individuals. Preferences were typically based on a limited range of activities that the individual had the opportunity to participate in at the facility. Outcomes related to preferences were general statements that ensured that the individual would have opportunities to continue to participate in those same activities with little discussion on how those preferences could be expanded or used to develop new skills. Lists of preferences in the ISPs in the sample were individual specific. IDTs, however,	Noncompliance

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		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 prioritized needs or preferences. ISPs in the sample provided few opportunities to gain exposure to new activities and learn new skills. As noted in F1e, a majority of plans in the sample offered individuals opportunities to visit in the community, but stopped short of offering opportunities for true integration, such as attending church in the community, banking in the community, joining community groups focused on specific interests, or exploring volunteer or work opportunities. In a review of six recent ISPs, none (0%) offered specific training to be provided in the community. While the community was occasionally 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 none were focused on gaining specific skills. 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. As noted in F1e, none of the ISPs reviewed included measurable outcomes to address barriers to community placement. The monitoring team found that many outcomes were not written in a way that staff could measure progress towards completion and/or that 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 #211 had an outcome to "attain employment skills to utilize on-campus and during employment in the community." The action steps included "make progress toward mastering functional work behaviors skills presented" and "work on campus and have opportunity to use functional work behaviors." Outcomes and action steps were not measurable and did not give clear directions for staff supporting him to provide consistent training. • Individual #80 had an action step in her IHCP to address her risk for choking and aspiration. One of her action steps stated "will be assisted with pleasure	Noncompliance

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		feedings according to the dining plan to determine mealtime instructions, consistencies, and devices." Implementation was assigned to the DSP. It was not clear what supports were needed or what would constitute progress. 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. Comments regarding discipline specific findings included: <u>Behavioral Health:</u> Individualized measurable treatment strategies based on identified behavioral needs were developed. Examples include functional assessments and PBSPs, however, functional skills assessments and vocational assessments were not timely and, in general, assessments were not consistently used to develop SAPs. <u>Habilitation Therapy:</u> There were measurable goals established for direct therapies across OT, PT, and speech, but these were not included in the ISP. <u>Nursing:</u> For the majority of the records reviewed appropriate supports were developed when IDT members identified needs or barriers to achieving outcomes. For example, Individual #297's recent surgery interventions identified needs that included the use of "no restraints of any kind." ISPAs were held to address her needs for increased supervision. Although the Comprehensive Nursing Assessments and their associated Integrated Health Care Plans had a place marker for the individual's goals, less than half of the IHCPs included statements regarding their treatment strategies. Most goals were not realistic/holistic and did not include sufficient interventions to meet their identified health care needs. 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. As noted in F1e, ISPs did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his or her needs. Although areas of progress were noted in terms of developing measurable outcomes and action steps, the facility was not in compliance with this provision.	
	3. Integrates all protections,	Assessments were not always submitted 10 days prior to the annual IDT meeting and	Noncompliance

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	services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	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. For the most part, these continued to be stand-alone plans. The development of action plans that integrated all services and supports was still an area with which the facility struggled. Action plans to address outcomes typically included reference to ancillary plans (e.g., PNMP, communication plan, PBSP), however, strategies from those plans were not integrated into supports with strategies specific to achieving the outcome. For example, Individual #521's ISP included an outcome to live in the most integrated setting. Action steps listed ancillary plans without specific supports and how those related to achieving the outcome. The facility had made progress in including supports recommended by discipline specific assessments into SAPs in the sample reviewed. SAPs generally listed recommendations cut and pasted from communication and behavioral assessments, however, strategies were rarely specific to the outcome being implemented. 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 annual ISP meetings and pre-ISP meetings indicated IDTs were making minimal progress towards integrating protections, services, and supports into one comprehensive plan. Better discussion among disciplines occurred, though discussion did not result in an integration of supports at the ISP meetings observed. • None of the eight plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. 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	<u>Method for implementation</u>	Noncompliance

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	implementation, time frames for completion, and the staff responsible;	As discussed in F2a2, some action steps in the sample of ISPs reviewed did not include clear methodology for implementation. 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. Each action step should state a measurable action the individual will perform, include the frequency, method of documentation and reporting requirements, and designate the assigned person for implementing and reviewing progress. IHCP action steps were generally brief statements of action to address the risk or references to additional plans (e.g., PNMP, PBSP). Most did not include methodology or criteria for monitoring effectiveness of intervention. The following are examples of outcomes that did not include sufficient information to ensure consistent implementation and allow staff to measure progress or regression. • Individual #521 had an outcome to attend programing at the ACE center monthly. The ISP did not describe supports needed or what activities/training she would participate in when there. She had an action step in her IHCP to address her weight that stated "encourage/educate individual on following her diet." There were no further instructions to ensure that staff consistently implemented the action. It was not clear what criteria would be used to measure progress. • Individual #386 had an outcome to visit his grandmother weekly. His ISP did not include what supports would be needed or offer specific information on how this would be implemented (e.g., transportation needed, day of the week for the visit). He had an outcome to improve his math skills with an action step to receive training in the area of math. There were not implementation strategies to guide staff in providing specific training or measure progress. <u>Time frame for completion</u> A sample of ISPs was reviewed to verify that action steps included a time frame for completion. All action steps reviewed included projected completion dates. In most 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> Outcomes 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 facility was not in compliance with the requirement for identifying methods for	

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		implementation.	
	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 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 assessments, 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 in key areas of their lives. For example, outcomes did not address increasing independence in routine household activities, such as laundry, yard work, and meal preparation. As noted in F2a3, recommendations of each discipline were not effectively integrated into the outcomes, action plans, and teaching strategies. Teaching and support strategies were not sufficient to ensure consistent implementation of outcomes. None (0%) of the ISPs in the sample included adequate outcomes for functional participation or integration in the community. For example, there were no outcomes to shop in the community for food to prepare a meal, complete transactions at a community bank, pick up prescriptions at the pharmacy, seek membership at a gym or library, or take a community art or fitness class. Vocational outcomes were not found that would develop vocational skills needed for community employment. Vocational skills were general in nature and did not address barriers to working in 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 objective analysis of the individual's progress, the person(s) responsible for 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. <u>Data to be collected</u> 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	Noncompliance

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	data collection, and the person(s) responsible for the data review.	struggling with developing measurable outcomes with methods that would allow for consistent data collection to permit the objective analysis of progress. <u>Frequency of data collection</u> For the sample reviewed, action steps typically included the frequency of implementation. Most action steps indicated how often the action step should be implemented in terms of weekly, monthly, quarterly, or annually. Program developers should list frequency in concrete terms, even specifying the day of the week and time for training when feasible to ensure consistent implementation. Individual #386's ISP was an example of a support plan that did not adequately specify the frequency of data collection. His ISP indicated that each action step would be implemented "one time." This included actions steps that should have been implemented with consistent frequency. For example, he had outcomes to attend school and receive training in math. Both action steps stated "one time" as the frequency for implementation. <u>Person responsible for collecting and reviewing data</u> As noted in F2a4, outcomes 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 facility was not yet in substantial compliance with this provision.	
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.	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 small sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in all (100%) of records reviewed. Data reviewed for ISP submission between 10/31/13 and 3/31/14 indicated that, of 310 individual notebooks reviewed, 87% included a current ISP with IHCP, PBSP, and SAPs. As noted in other sections of this report, the monitoring team found that outcomes were rarely written in measurable terms, so that those monitoring the plan could determine when progress was made or if the outcome was completed. Additionally, teaching and support strategies were not comprehensive enough to ensure that staff knew how to implement the outcome and provide appropriate supports based on assessment recommendations.	Noncompliance

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		The facility identified staff turnover and the frequent use of "pulled" staff in some homes as barriers to ensuring that all staff were trained on support plans prior to working with individuals. Progress was noted in ensuring that ISPs were accessible to staff designated to implement the plan. 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. Teaching and support strategies should provide a meaningful guide to staff responsible for plan implementation.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	QIDPs were assigned overall responsibility for monitoring services and supports in the ISP. The facility self-assessment indicated that, from a sample of 30 monthly reviews, 10 (33%) were completed on time and included adequate documentation of the status of all outcomes. A review of QIDP monthly reviews indicated that none of the reviews (0%) in the sample adequately reflected the status of all outcomes and services included in the ISP. For example, • The January 2014 through March 2014 QIDP monthly reviews for Individual #386 indicated that no data were available for participation in substance abuse, group sessions, and individual counseling. There was no documentation of follow-up by the QIDP regarding the lack of available data. • Individual #80's monthly reviews for December 2013 through March 2014 did not note the status of outcomes in her IHCP. The QIDP monthly review/summary column noted "will continue to monitor" without a review of the efficacy of supports. She was at high risk for aspiration and gastrointestinal issues. In March 2014, several instances of vomiting were noted. It was not evident that the QIDP reviewed supports related to her health risks. • Individual #535's monthly reviews from December 2013 through March 2014 indicated that data regarding targeted behaviors in his PBSP were not consistently available for review. • Individual #221's monthly review dated 3/21/14 did not note the status of action steps related to his outcome for reading. Progress on action steps related to his outcome to engage in preferred activities noted "none." It was not clear whether the outcome was implemented or whether there was no progress. A sample of QIDP monthly reviews were reviewed to determine if the IDT convened as	Noncompliance

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		needed when there was a change in the individual's status or support needs, evidence that the ISP was not being implemented, or a lack of progress towards outcomes that might require revision of the ISP. The monitoring team found that the monthly review process was not adequate for ensuring that ISPs were modified, when appropriate. For example, • Individual #386's monthly reviews from October 2013 through March 2014 indicated that he had not made progress on his money objective. Each month, the QIDP noted no progress/continue objective. There was no indication that the team met to discuss his lack of progress or modified his supports. • The QIDP monthly reviews for Individual #80 indicated 0% progress for three of her SAPs from November 2013 through March 2014. There was no indication that the team met to discuss his lack of progress or modified his supports. • Individual #113 was the victim of confirmed physical abuse resulting in a fractured jaw that required significant changes in supports on 1/29/14. His monthly reviews through April 2014 did not indicate that supports were revised. His IHCP was not updated following the incident. His monthly reviews showed a lack of progress on all day programming outcomes. There was no indication that the team met to review outcomes and supports. The monitoring team found that individual team members were not consistently following up on their responsibility to monitor services and supports and document specific progress or regression. Additionally, supports were not always modified when the individual experienced a change of status, regression occurred, and/or outcomes were not achieved. The monitoring of behavioral services and supports had improved. For example monthly PBSP progress notes were completed and indicated that action occurred when the individual outcomes were not achieved. Nursing services and supports were consistently monitored and specific progress or regression was documented to include when the individual had signs and symptoms of regression. For example, Individual #628 was consistently monitored for his risk of aspiration that included his progress and regression with taking food/fluids and medications. The record contained evidence of frequent IDT meetings to include change of status. Documentation by the habilitation therapy department indicated that direct therapy was reviewed after each session with data and IPNs recorded. Monitoring for effectiveness of the PNMP and communication supports was not routinely conducted for the samples reviewed (i.e., less than quarterly in most cases).	

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		The monitoring team found that the current IDT process was not adequate for implementing, assessing, and monitoring of services for individuals. 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. During the week of the monitoring visit, two annual IDT meetings were observed. At the two meetings observed, • Meetings were lengthy, yet very few revisions were made to current supports. IDTs continued outcomes that were not achieved the previous year with little changes in supports or discontinued the outcome without considering more appropriate action steps to teach the identified skill or barriers to implementation. • The IDTs were still not adept at developing integrated action plans based on information from assessments. • Outcomes and action steps were not necessarily developed based on priorities established for the individual. • Teams were still struggling with using strengths and preferences to provide new training opportunities with a focus on developing new skills. • IDTs were still struggling with developing measurable objectives to track progress or regression. The QIDP Director reported that there had been significant turnover among QIDPs and new QIDPs were still learning to use the statewide ISP format to develop the ISP. All new employees were required to complete Supporting Vision, the statewide training on the ISP process. Data collected by the training department for new employees during showed 100% of all new employees completed training on the ISP process. To move forward, the facility will need to ensure that comprehensive ISPs are developed that include supports to address all identified needs and that training on new or revised supports occurs within 30 days of development.	Noncompliance

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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.	A small sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current ISPs were available in all records reviewed. This was good to see, however, it will be necessary to ensure that plans are revised when warranted to gain substantial compliance with this provision. IDTs were still not ensuring that plans were monitored for efficacy and revised when outcomes were met or when there was regression or lack of progress towards outcomes. The facility self–assessment indicated that 100% of all new admissions (36) between 10/31/13 and 3/31/14 had an ISP meeting within 30 days of admission. During the same time period, 100% of annual ISP meetings were held within 365 days of the previous annual ISP meeting. The monitoring team reviewed data in regards to ISPs held April 2013 through March 2014. The facility reported that 14 of 184 (8%) ISPs were not filed within 30 days of development. An adequate review process will need to be in place to ensure that supports are revised as needed. At both ISP meetings observed, the IDT acknowledged that little progress had been made on most outcomes and some outcomes were not implemented for the previous year. The IDT should have met prior to the annual meeting and revised outcomes and supports when it was noted that outcomes were not implemented or lack of progress was noted. The facility needs to continue to focus on ensuring that an adequate review process is developed and that plans are revised when outcomes are met, individuals experience a change of status, there is a lack of progress towards the accomplishment of outcomes, or when regression is noted.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility was using the statewide section F audit tool to monitor requirements of section F. Other tools had been developed to measure timeliness of assessments, participation in meetings, and facilitation skills. The facility was meeting regularly with the QA department to review results of audits of the ISP process. Corrective action plans were developed to address deficiencies noted through the self-assessment process. It was not clear that adequate data were being gathered and analyzed for all data that would be relevant to this provision. For example, meeting attendance was being tracked by the QIDP department, but it was not evident that IDTs were correctly identifying which disciplines were key team members during the pre-ISP meeting, thus, attendance percentages did not accurately reflect compliance with attendance requirements.	Noncompliance

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		Data presented often did not support the facility's justification for noncompliance ratings in regards to compliance with the requirements of the Settlement Agreement. This suggested that the facility was not confident in the quality of data gathered. For example, • Data gathered by the facility indicated that 100% of staff were trained on current ISPs, however, the self-assessment noted that plans were not consistently implemented due to a high rate of staff turnover. As noted in section D, lack of staff training on individual specific supports contributed to a number of incidents and injuries at the facility. • Data obtained through the section F monitoring tool indicated that 100% of the ISPs reviewed included objectives for all plans that were integrated into the ISP. The self-assessment, however, noted that F2b was not in substantial compliance because collaboration was not occurring with consistency or not being captured in the final ISP document. Progress had been made towards developing an effective quality assurance system to identify problems with the ISP and implementation. To move forward, the facility needs to focus on the quality of data gathered through the assessment process.	

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 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 – 2014 o Medical Review Committee Meeting Summaries 2013 -2014 Interviews and Meetings Held: o Christopher Ellis, MD, Medical Director o Chrissy Sykes, RN, Medical Compliance Nurse Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Psychiatry Clinics o Dental Clinic o Daily Clinical Services Meetings o Medical Review Committee Meeting
	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 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 five items listed: (1) attendance at the clinical services meeting, (2) attendance at the annual ISP meetings, (3) tracking of issues discussed at the clinical services meeting, (4) attendance at post hospital ISPAs, and (5) discipline attendance at committee meetings. The facility reported data for the first three items. For the fourth item, data for February 2014 and March 2014 were reported, and for item number five, no data were reported. As discussed in various sections of this report, the facility must address the selection of metrics. Reporting that physicians attended 100% of all ISPs "when attendance was requested" does not accurately reflect physician participation in the ISP process,

	and indicates poor metric selection. That is, the metric is not a valid one. The rules of selecting valid metrics should be applied for all components of the self-assessment. For provision G2, facility staff reviewed the physicians documentation in the IPNs and the tracking of the non-facility consultations. The overall compliance scores were 82% and 78% respectively. 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 are 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, which must be evaluated to determine a compliance rating. The facility found itself in noncompliance with provision G1 and G2. The monitoring team found the facility to be in noncompliance with G1 and substantial compliance with G2.
	Summary of Monitor's Assessment: The monitoring team found evidence of integration of clinical services, but there was no significant progress seen in this area. As noted in previous reviews, there was no overarching plan to move forward in this area. There was no specific policy related to integration of clinical services. The minimum common elements policy included a list of multidisciplinary committees. The monitoring team has stated in the past that committee attendance alone does not demonstrate integration of clinical services. Some facility staff questioned why the facility did not focus more on provision G and provision H. Staff believed they worked to provide services in an integrated manner, but some expressed concerns, specifically citing the need to have greater participation of the medical staff in the risk process. 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 facility needs to devote some attention to ensuring that services are delivered in an integrated manner and should have a plan for how this will be achieved. The medical director serves as the facility lead for this provision and will have the responsibility for orchestrating the process. There was significant improvement on the part of the primary providers in the completion of the IPN entries for outside consultations. This improvement was first noted with the implementation of the revised IPN format in October 2013. The subsequent revision implemented in February 2014 resulted in even further improvements resulting in this provision moving into substantial compliance.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	MSSLC continued to lack an overarching plan to move the facility towards substantial compliance in this provision. Throughout the week of the compliance review, there was little discussion of integration of clinical services. As noted in the monitoring report for the June 2013 review, the policy for the minimum common elements did not address the integration of clinical services as it only listed attendance at committees. The monitoring team has continuously emphasized that committee attended is not evidence of integration of clinical services and that facilities must have other evidence to demonstrate that integration occurs. If the facility chooses to present committee attendance data, it must be valid and reliable. Data were presented for several meetings, such the daily clinical services meetings. While the attendance appeared to be good, the exact significance of the data was not clear. For example, according to the self-assessment, medical attended 100% of all clinical services meetings from October 2013 through March 2014. It was not clear if this score was intended to reflect 100% attendance of all providers over a six-month period. This calls into question both the reliability and validity of the data. The self-assessment presented data on attendance at ISPs and some ISPAs. Again, the facility has much work to do in this area. In terms of just determining its status, much thought is needed in selecting the appropriate metrics and collecting accurate data. 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 the medical compliance nurse to discuss the status of sections G and H. Much of the discussion focused on meeting attendance, such as the clinical services meeting and participation in ISPs and ISPAs. The medical director also discussed issues related to transportation to appointments and corrective actions regarding no-shows for audiology appointments. 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, pharmacy director, dental director, and the behavioral health services 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.	Noncompliance

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		The monitoring team attended a number of committee meetings where the various clinical disciplines participated and good integrated discussions occurred: • 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 this report. One new activity that the monitoring team did not actually observe, but was provided some documentation of, was the new pneumonia review process. This was a good example of how clinical services came together to deliver services in an integrated manner. The clinical disciplines were each responsible for reviewing the selected individual using a checklist. The individual was reviewed in the MRC and recommendations regarding care were made. There was evidence that follow-up on the recommendations was done in subsequent meetings. This was one way of demonstrating an outcome of meeting activities – the actual implementation and follow-up of the recommendations that were generated during the meeting. The following are some examples of integration based on observations, interviews, and other activities listed above: • There were a number of collaborative efforts related to safe medication practices: o Medication variances were reviewed by medical, nursing, and pharmacy to ensure that each was appropriately categorized. o The nursing and medical departments worked to clarify medication times to decrease errors. • OTs, PTs, and SLPs completed Comprehensive Assessments and Assessments of Current Status collaboratively on at least an annual basis as well as in the interim for acute concerns or changes in status. The PNMT members represented OT, PT, SLP, RN, and RD, and worked together to assess and provide PNM supports to individuals and the IDTs. There was, however, limited evidence of collaboration with behavioral health services to address communication needs for individuals with these needs as they related to behavior • When quarterly psychiatry clinics or other psychiatric clinical consultation occurred, there were generally members of the IDT present for integration including psychology, nursing, pharmacy, and therapy services • Behavioral health services demonstrated functional integrated services with	

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		dentistry. Those two departments appeared to work in an integrated manner to address the needs of individuals who refused to tolerate routine dental examinations. • Behavioral health services and psychiatry continued to make progress in functional integration. 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 providers attended only 12.5 % of the annual ISPs from December 2013 to May 2014. PCPs attended a total of 23 ISPs with 13 meetings attended in May 2014. Attendance for the actual reporting period was 3%. • The psychiatrists participated in few ISP meetings. Since the last monitoring visit, psychiatric participation in the ISP process had not improved. Data revealed that psychiatry attended 13% of the ISP meetings for individuals followed by psychiatry clinic between the dates of 12/3/13 and 5/29/14. • The monitoring team attended a facility level meeting related to risk where all of the clinical disciplines attended, with the exception of medical. During this meeting, facility staff was asked about integration efforts. Several indicated that they were aware that this was needed and they had done some work in this area independently, but never received any feedback or saw further progress. Moreover, they indicated that the facility's risk process would benefit from increased medical participation. 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: 1. 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. 2. Clinical disciplines should track attendance at ISPAs. Medical should continue the post-hospitalization ISPA attendance tracking started in February 2014 due to the importance of medical participation in developing plans related to a change in health status. 3. The facility should address the issues noted above. 4. The state should provide additional guidance in the form of a policy.	

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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: • 33 of 40 (83%) consultations were summarized by the medical providers in the IPN within five working days. Moreover, starting in March 2014, the IPN notes included a summary statement regarding the reason for the consult and significance of the findings, agreement, or disagreement with the recommendations, and the need for IDT referral. This system appeared to be effective in relaying information regarding consultations to the IDTs. 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 <u>five working days.</u> The facility implemented a new IPN template in February 2014. The template was an IPN note that included all of the required elements: (1) acceptance or rejection of the consultants recommendations, (2) explanation of the consultation and the plan of care, and (3) a decision regarding referral to the IDT. The monitoring team found that documentation was consistent in the record sample reviewed beginning in March 2014. This was a continuation of the adequate documentation that several providers were noted to do during the December 2013 compliance review. A different template had been implemented just prior to that review. The self-assessment found an overall compliance rate of 82%. The monitoring team found a compliance of 83% for the review period, noting that nearly all consults completed during the last three months included the appropriate elements. Based on these findings, the monitoring team finds this provision in substantial compliance. It was observed that there were differences in the documentation of providers and the medical director should ensure that all providers are complying with the requirements. This will be needed in order to maintain substantial compliance. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of noncompliance and finds this provision in substantial compliance for the reasons stated above. To maintain substantial compliance, the monitoring team offers the following recommendations for consideration:	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		1. The medical director should ensure that all providers document as required. 2. Providers should always clearly state the consult specialty and date of consult being addressed. 3. The medical director should ensure that systems are in place so that primary providers receive consults in a timely manner.	

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 o Chrissy Sykes, RN, Medical Compliance Nurse Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Psychiatry Clinics o Dental Clinic o Daily Clinical Services Meetings
	Facility Self-Assessment: 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 self-assessment presented data for provisions H1, H2, H3, and H5. The facility rated itself in substantial compliance with provision H2. Provisions H1, H3, H4, H5, and H6 and H7 were self-rated in noncompliance. The monitoring team concurred with the facility's self-ratings.

	Summary of Monitor's Assessment: MSSLC made no progress in this provision. A policy for the minimum common elements of clinical care was approved in May 2013, but there was no plan for how the facility would move towards substantial compliance in this area. MSSLC was tracking assessments, but this was limited to timeliness only. There was no documentation provided relative to the quality of the assessments. There was also no review of any unscheduled/interval assessments. The medical director had started doing chart audits related to the Annual Medical Assessments, but did not present those data for section H. The lack of work in this area was reflected by the lack of data presented in the self-assessment. Provision H1 included data on the timeliness of scheduled assessments and ISPA attendance for February 2014 and March 2014. Provision H3 provided a generic statement that some clinical protocols were utilized. Provision H5 repeated the data from provision H1 and no data were presented for provisions H6 and H7. Based on discussions with the medical director, who served as facility lead for this provision, and the medical compliance nurse, it was quite evident that this provision had received little attention. The state medical services coordinator had developed 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. The medical director and medical compliance nurse were both aware of the requirements and had received the draft guidelines. It was not clear why progress had halted. Clinical indicators were developed at the time of the December 2013 compliance review, but no further work on this was presented. Some clinical staff reported during the week of the compliance review that they worked on section H. However, the products of this work were not presented to the monitoring team. Since MSSLC has made no demonstrable progress in this area over a number of years, it is unlikely that any progress will occur without a specific written plan of action. This will undoubtedly require intervention and oversight by the facility director/designee.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to	There was no significant progress in this area apart from the development of a policy to guide the provision. This policy, which was based on guidelines in the state draft policy, required each department to have procedures for performing and documenting assessments and evaluations. Furthermore, assessments were to be completed on a scheduled basis, in response to changes in the individual's status, and in accordance with commonly accepted standards of practice.	Noncompliance

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	developments or changes in an individual's status to ensure the timely detection of individuals' needs.	The self-assessment presented data that simply did not appear to be meaningful. For example, it was reported that pharmacy completed 100% of departmental assessments each month. It is well documented that the pharmacy had very low compliance rates in completing assessments as required by state office guidelines. The facility's target should be to complete QDRRs consistent with state guidelines. 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%. The quality varied among providers. AMAs are discussed in detail in section L1. • Quarterly Medical Assessments - Quarterly evaluations were found in 80% of the records reviewed. • Quarterly Drug Regimen Reviews - The compliance for timely completion for the reporting period of months of October 2013 - to March 2014 was 28.7%. 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%. • MSSLC provided data that 96% 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 73% were seen by psychiatry and completed within the appropriate time limits. This was a decrease from the compliance rates of 98% and 100% reported during the last compliance review. • For 18 of the most recent Admission/Annual/ Comprehensive Nursing Assessments/ Quarterly Nursing Assessments/Physical Assessments reviews, 95% were completed in accordance with the individual's ISP dates. Assessments were performed in response to a change in the individual's status. • OT, PT, and SLPs conducted annual assessments for individuals with identified needs and additional interim assessments as indicated for changes in status. These served to determine if changes in the PNMP or other supports were needed. The PNMT nurse also conducted a post-hospitalization assessments for individuals hospitalized with a PNM-related issue. • Functional assessments were completed and timely for only 26% of individuals with PBSPs. Similarly, only 57% of individuals at MSSLC had a full psychological	

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		assessment, and only 58% of individuals had an annual psychological update. There was some evidence that functional assessments were redone in response an increase in problem behavior. <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 3. 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. • The monitoring team observed the psychiatrist relying upon the diagnostic criteria in an effort to appropriately diagnose individuals. Moreover, records in the record sample provided 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.	The self-assessment indicated nine clinical pathways were reviewed to ensure protocols were utilized to govern treatments and intervention. The self-assessment did not specify who reviewed this information or how this was done. It provided a generic result stating that six of the nine protocols were being utilized. The section H state draft guidelines indicated that facility staff would utilize the clinical pathways, guidelines, and protocols to govern treatments and interventions as 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. <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	Noncompliance

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		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, and 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 self-assessment had no data for this provision item. 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. During the December 2013 review, the medical director reported that clinical indicators were developed for osteoporosis, constipation, aspiration pneumonia, and diabetes mellitus. The next step was to develop tools to objectively assess treatments. During a facility level meeting that was conducted to discuss MSSLC's risk process, several staff indicated that they had done work in this area, but received no follow-up on the work that was done. The monitoring team was not provided any additional information for this provision item. The comments made during the risk meeting were shared with the medical director. <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. 2. Audit tools should be developed, based on clinical indicators, for the identified conditions.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The facility assessed compliance with this provision by looking at timely completion of ISP assessments for the clinical disciplines and PCP attendance at ISP meetings. Compliance with completion of assessments ranged from 76% to 98%. PCP attendance was 3% for the reporting period. The proposed section H guidelines indicated that the individual's health status was discussed in the annual ISP and ISPA as identified by the IDT and a plan was developed to	Noncompliance

#	Provision	Assessment of Status	Compliance
		address the needs of the individual. Additionally, the facility tracked data in development of the identified health plan. The monitoring team agrees that the ISPs and ISPAs are integral to monitoring health status. That is, the rationale for improving participation of the primary medical providers. 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. MSSLC had a number of processes in place at the time of the compliance review that were capable of monitoring health status if properly executed: • 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) • Medical Review Committee/ Pneumonia Review Process • Internal/external medical audits • Medical director chart audits While a number of good systems were in place, 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 generally lacked risk assessments. • The lack of primary provider participation in the ISP process contributed to a lack of medical participation in the overall risk process. • The Annual Medical Assessments in many instances lacked appropriate plans. • Psychiatry participation in the ISP process was poor. • Additional work was needed in improving the accuracy of data, particularly seizure management data. 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 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.	

#	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. 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 presented no data for this provision item. This provision addresses the need to develop systems that have the capacity to identify changes in status and modify treatments in response to those changes. 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 agrees with the facility's self-rating of noncompliance. 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: ○ DADS Policy #006.1: At Risk Individuals dated 12/29/10 ○ DADS SSLC Risk Guidelines dated 4/17/12 ○ List of individuals seen in the ER in the past year ○ List of individuals hospitalized in the past year ○ List of individuals with serious injuries in the past year ○ List of individual at risk for aspiration ○ List of individuals with pneumonia incidents in the past 12 months ○ List of individuals at risk for respiratory issues ○ List of individuals with contractures ○ List of individuals with GERD ○ List of individuals at risk for choking ○ Individuals with a diagnosis of dysphagia ○ List of individuals at risk for falls ○ List of individuals at risk for weight issues ○ List of individuals at risk for skin breakdown ○ List of individuals at risk for constipation ○ List of individuals with a pica diagnosis ○ List of individuals at risk for seizures ○ List of individuals at risk for osteoporosis ○ List of individuals at risk for dehydration ○ List of individuals who are non-ambulatory ○ List of individual who need mealtime assistance ○ List of individuals at risk for dental issues ○ List of individuals who received enteral feeding ○ List of individuals with chronic and acute pain ○ List of individuals with challenging behaviors ○ List of individuals with metabolic syndrome ○ List of individuals who were missing and/or absent without leave ○ List of individuals required to have one-to-one staffing levels ○ List of 10 individuals with the most injuries since the last review ○ List of 10 individuals causing the most injuries to peers for the past six months ○ Data reports regarding the submission of assessments for IDT review prior to annual ISP meetings ○ A list of all individuals at the facility with the most recent ISP meeting date and date ISP was filed. ○ Draft ISPs and Assessments for Individual #519 and Individual #557 ○ ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly

	Reviews (for a subsample): • Individual #113, Individual #884, Individual #386, Individual #261, Individual #211, Individual #80, Individual #816, Individual #521, and Individual #535. Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; o Charlotte M. Kimmel, Director of Behavioral Services o Patrick Samuels, Incident Management Coordinator o Ramona Echols, QIDP Director o Craig Burgess, Assistant QIDP Director o Don Morton, Assistant Director of Programs Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 6/2/14 and 6/3/14 o Longhorn Morning Unit Meeting 6/4/14 o PET II Meeting for sections C, D, K, and J o ISP preparation meeting for Individual #539 o Annual IDT Meeting for Individual #557 and Individual #519 o ISPA for Individual #451 regarding restraints
	Facility Self-Assessment: MSSLC submitted its self-assessment updated 5/9/14. 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. Since the last review, the facility developed a new section I monitoring tool. Use of the tool began in February 2014. To assess compliance, the facility: • Reviewed IRRFs to ensure all individuals had current risk ratings • Reviewed the QIDP Assessment Tracking Spreadsheet to determine if assessments were completed and submitted to the IDT at least 10 days prior to annual ISP meetings. • Reviewed a sample of Settlement Agreement Monitoring Tools (sample size 42) • Reviewed a sample of individual notebooks to confirm inclusion of current IHCPs. The facility self-rated each of the three provision items in section I in noncompliance. While the monitoring

	team agreed with the facility's findings for noncompliance, it will be necessary for the facility to develop an adequate self-assessment process to identify areas for focus in order to move forward.
	Summary of Monitor's Assessment: The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. The facility was in the process of retraining QIDPs and IDTs on completing the risk identification process. A large turnover in the QIDP department had necessitated new training on the risk process. The facility continued to train DSPs on identified risks for individuals and how to implement supports to address those risks. The facility acknowledged that a barrier to ensuring consistent implementation of supports to address risks was staff turnover and the pervasive use of "pulled" staff in some homes. The monitoring team observed the risk identification process at two ISP meetings and noted progress made with the risk identification process. Notably, each discipline presented relevant information during the risk determination process that was essential for determining risk in each area identified by the IRRF. Both teams engaged in integrated discussion regarding the identification of risks, however, both IDTs had difficulty establishing consensus among disciplines regarding risk factors that impacted risk ratings. For example, Individual #519's IDT engaged in a long debate regarding how insomnia impacted his risks. Without consistent data regarding his sleep patterns, the team was unable to reach a consensus. The facility continued to struggle with ensuring that all assessments were completed and available for review prior to annual ISP meetings. Without up-to-date assessment information, it was unlikely that accurate risk ratings could be assigned during annual IDT meetings. As noted in section F, the facility did not have an adequate system in place to monitor supports. Teams were not consistently documenting the completion of assessments and resulting recommendations and supports were not monitored to ensure consistent implementation. 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. Provision I3 requires evidence that plans were implemented in a timely manner once risks were identified. The facility reported that due to the turnover in the QIDP department, ISPs were often not filed and available for implementation within 30 days of development. The QIDP Director indicated that this was a focus area for the QIDP department. 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.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The state policy, At Risk Individuals 006.1, required IDTs to meet to discuss risks for each individual at the facility. The at-risk process was to be incorporated into the IDT meeting and the team was required to develop an integrated health care plan (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 annual ISP meetings. 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). Each discipline entered draft information into the IRRF prior to the meeting for review by the IDT in preparation for discussion during the annual ISP meeting. • At the IDT meetings observed, each discipline presented relevant information during the risk determination process. Both teams engaged in better integrated discussion regarding the identification of risks. • IDTs were still not adept at analyzing data and revising supports when negative outcomes were identified. For example, at Individual #519's annual IDT meeting, the QIDP reviewed data regarding incidents and injuries over the past year. He had 35 injuries, including seven that were the result of peer-to-peer aggression. The team reviewed the data, but did not revise supports to reduce his risk of injury. Individual #557's team reviewed her risk rating for aspiration and noted that her history of vomiting and GERD issues put her at risk for aspiration. The nurse reported that she continued to experience episodes of vomiting over the past year. The team agreed that she remained at risk, but failed to analyze data regarding vomiting to determine if supports in place should be revised (e.g., dining plan, medications). The team agreed to continue supports as written. • Neither team developed action plans to address risk that included measurable outcomes with implementation dates, completion dates, and/or responsible staff for implementation and monitoring of supports. • In some cases, IDTs continued to base ratings on whether or not negative outcomes had occurred, rather than evaluating the risk for negative outcomes. For example, Individual #519's IDT determined that he was not at risk for diabetes because he showed no symptoms of diabetes. The team failed to evaluate a number of factors that contributed to his risk for developing diabetes,	Noncompliance

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		included obesity, tobacco use, and use of multiple psychotropic medications. For Individual #557, the IDT did not consider her obesity or medications that might impact her risk for cardiac disease. IDTs should focus on identifying supports to minimize risk prior to the occurrence of negative outcomes. The state policy required that all relevant assessments be submitted at least 10 days prior to the annual ISP meeting and accessible to all team members for review. The facility was tracking submission of assessments. The submission of assessments was a barrier to accurately identifying risks and support needs for individuals. Data submitted by the facility 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 for November 2013 through April 2014.	

Month	Late Assessments	Percentage Submitted On Time
November 2013	134/487	72%
December 2013	126/479	74%
January 2014	179/513	65%
February 2014	128/550	77%
March 2014	84/425	80%
April	65/448	85%

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. In two of eight (25%), the team obtained the needed relevant assessments. That is, two of the individuals in the sample had all assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting.

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. 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 some 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.

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

#	Provision	Assessment of Status	Compliance
		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 and documented. This raised the question of whether 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. It was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time when recommended following a change of status. 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. When recommendations for further assessment were found in the IHCPs, the date of completion was not documented. Thus, it was impossible to determine if it was actually timely completed. For example, • Individual #113 experienced a change of status following a serious injury (broken jaw) on 1/29/14. His IRRF and IHCP were not updated to reflect additional assessment of risk and/or changes in supports. ISPAs documented that the IDT met on 1/30/14 and again on 2/4/14 to discuss his injury. The ISPAs, however, did not document discussion regarding his need for further assessment, change in risk status, or change in supports. • Individual #211 was rated as high risk for constipation. On 1/13/14, his IDT met and acknowledged that he had been constipated for four days. His ISPA indicated that he would "go off campus today for an x-ray as soon as transport arrives." No further assessment or discussion was documented. Additionally, he was at risk for weight gain. His IHCP included supports to monitor his weight and encourage weight loss. His weight records, nursing reviews, and QIDP monthly reviews documented that he steadily continued to gain weight each quarter over the past year. There was no indication that the IDT met to review or revise supports when not effective. The QIDP monthly review process did not document with any detail the 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 the records selected by the monitoring team for review, 10 individuals that were due their annual ISP (January 2013 to June 2014) had a corresponding ISP. Five of the 10 individuals were new admissions. Ten of 10 (100%) of the records included a completed Admission/Annual Comprehensive Nursing Assessment and accompanying Nursing Physical Assessment. Nine of 10 (90%) of the records included sufficient Admission/Annual Nursing Assessments to assist the team in developing appropriate plans to adequately address the individual's 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 30 individual records for whom assessments had been completed to address the individuals' at risk conditions (i.e., 10 full psychological records, 10 annual psychological assessments, and 10 functional assessments), all (100%) included an adequate behavioral assessment to assist the team in developing an appropriate plan. Only 57% of individuals, however, had a full psychological assessment and 58% of individuals had an annual update. Although progress was noted, the facility did not yet have an adequate system in place to ensure that all recommended assessments were completed in a timely manner.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the	The At Risk 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. The monitoring team found that IHCPs were filed in individual notebooks and accessible to staff designated to implement plans. This was positive to see. Data from March 2014 indicated that 44% of the individual notebooks reviewed by the QIDP department included current IHCPs, so this was significant progress for the facility. It was not evident that all IDT members were tracking the completion of assessments and documenting resulting recommendations. Documentation of plan implementation	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>was not consistent. Thus, it was not always possible to determine if IDTs implemented all recommendations from assessments within 14 days. For the QIDP monthly reviews, the QIDPs were not documenting implementation of action steps or reviewing status of IHCP outcomes with enough detail to determine the status of outcomes. Data collected by the facility for March 2014 showed the following compliance rates with disciplines designated to monitor effectiveness of supports.

<table>
<tr><td>Discipline</td><td>Compliance percentage</td></tr>
<tr><td>QIDP</td><td>20%</td></tr>
<tr><td>Nursing</td><td>100%</td></tr>
<tr><td>Psychology</td><td>43%</td></tr>
<tr><td>Habilitation Therapy</td><td>86%</td></tr>
<tr><td>Dental</td><td>83%</td></tr>
<tr><td>Nutrition</td><td>29%</td></tr>
<tr><td>Pharmacy</td><td>33%</td></tr>
<tr><td>Psychiatry</td><td>38%</td></tr>
</table>

The state 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.

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. Document the implementation of action plans.
3. Document that clinical data is gathered and reviewed at least monthly.
4. Document action taken to revise supports when data indicates that current supports are not effective.</td><td></td></tr>
</table>

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 four 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 Description of administrative support offered to the psychiatrists o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who have a diagnosis of seizure disorder o For the past six months, minutes from the committee that addresses polypharmacy o Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy, including medications in process of active tapering; and justification for polypharmacy o Facility-wide data regarding polypharmacy, including intra-class polypharmacy o For the last 10 newly prescribed psychotropic medications, psychiatric treatment review/progress notes documenting the rationale for choosing that medication; signed consent form; PBSP; HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) o List of all individuals age 18 or younger receiving psychotropic medication o Name of every individual assigned to psychiatry clinic who has had a psychiatric assessment per Appendix B with the name of the psychiatrist who performed the assessment, date of assessment, and the date of facility admission

	○ Ten comprehensive psychiatric evaluations per Appendix B performed in the previous six months ○ A list of individuals requiring chemical restraint and/or protective supports in the last six months ○ Section J presentation book <u>Documents Requested Onsite:</u> ○ Psychiatric documentation completion rates ○ Facility policy and procedure regarding Reiss Screens ○ 10 examples of informed consent ○ Tracking spreadsheet for "Neuro-Psych" clinic ○ Tracking spreadsheet regarding physician attendance at ISP meetings ○ List of all individuals with a PSP ○ All data presented, doctor's orders, and Dr. Kendrick's documentation for psychiatry clinic 6/5/14 regarding Individual #539 ○ All data presented, doctor's orders, and Dr. Baratang's documentation for psychiatry clinic 6/4/14 regarding Individual #120, Individual #61, and Individual #365 ○ All data presented, doctor's orders, and Dr. Farber's documentation for psychiatry clinic 6/3/14 regarding Individual #233 ○ All data presented, doctor's orders, and Dr. Shet's documentation for psychiatry clinic 6/3/14 regarding Individual #209, Individual #170, and Individual #529 ○ All data presented, doctor's orders, and physician documentation from "Neuro-Psych" clinic 6/3/14 regarding Individual #154, Individual #109, and Individual #415 ○ The following documents for the individuals listed: Individual #386, Individual #154, Individual #853, Individual #290, Individual #75, Individual #519, Individual #98, Individual #385, Individual #257, Individual #297 • Identifying data sheet • Social History (most current) • Annual Medical Summary and Physical Exam (most current) • Quarterly Medical Review • Health Management Plan (most current) • Hospital Section for the last six months • Active Current Diagnoses Sheet • X-ray/Lab section (for the last six months) • Annual Weight Graph • EKG section for the last year • Psychiatry section (for the last nine months) including Appendix B evaluation • Neurology section (for the past year) • Seizure Graph/Record (Active) for the last year • Quarterly Nursing Assessment (most current) • Nursing Reports for psychiatry clinic for the past six months • Psychology reports for psychiatry clinic for the past six months • Psychology Evaluation (most current)

	• QDDP notes for psychiatry clinic for the past six months • Safety Plan/Crises Plan • MOSES/DISCUS results (for the last six months) • Reiss Screen • Pharmacy section (for the last six months) inclusive of Pharmacy Quarterly Drug Regimen Reviews • Physician's Orders for the last six months • Current list of all medications (e.g., MAR) • Consent section for psychotropic medication • Consent section for pretreatment sedation • Integrated progress notes (for the last six months) • ISP, ISP addendums, and signature sheets (for the last nine months) • Behavior Support Plan • Desensitization Plan • Human Rights Committee Review of consent for psychotropic medication, pretreatment sedation, and BSP (most current) for the last six months <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 Psychiatry staff meeting including Angela Johnson, R.N., Ms. Virginia Jackson, Ms. Bobbie Hall, Ms. Anita Brewer, and Drs. Kendrick, Shet, Farber, 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 Behavioral Health Services <u>Observations Conducted</u>: o Psychiatry clinic conducted by Ernest Kendrick, M.D. o Psychiatry clinic conducted by Eileen Farber, M.D. o Psychiatry clinic conducted by Prakesh Shet, M.D. o Psychiatry clinic conducted by Ramil Baratang, M.D. o "Neuro-Psych" clinic o Clinical Services meeting o Behavior Therapy Committee o Pharmacy and Therapeutics (P&T) Committee meeting o Polypharmacy Meeting o Behavioral Health/Psychiatry Meeting o Support Team 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 eight provision items: J1, J2, J5, J6, J7, J11, J14, and J15. The monitoring team agreed with six of these ratings J1, J5, J6, J7, J14 and J15. 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 to the types 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, based on additional document review, the monitoring team agreed with the facility self-assessment, but it was difficult to determine the facility's 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 six sections of provision J (J1, J5, J6, J7, J14 and J15). 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, and another who was board certified in child and adolescent psychiatry. Psychiatric services were provided only by persons who were qualified professionals, therefore, the facility met substantial compliance in J1. In discussions with the lead psychiatrist, medical director, director of behavioral health services, 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 behavioral health). Behavioral health services and psychiatry conducted a routine meeting together that included the director of behavioral health services, 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 behavioral health 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 behavioral health could be more integrated with psychiatry (e.g., identification of clinical indicators/target symptoms, data collection, collaboration regarding case formulation). The psychiatrist was not always provided appropriate data in order to make decisions regarding pharmacological 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. There were, however, noted deficiencies with regard to the timeliness of submission of clinical documentation. In regard to pretreatment sedation, there was minimal pretreatment medication administered at MSSLC, with the majority being given at another location (hospitals, such as for medical testing, and at dental clinics). This did not, however, free 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, regarding individuals 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). 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 allow comparison of scores over time. Although the Avatar system had been updated and allowed for physician clinical correlation and signature, there remained difficulties with the interface. It was reportedly complicated and time consuming. Pending the resolution of these Avatar limitations, the facility planned 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 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 completed a clinical fellowship in child and adolescent psychiatry. Prakesh Shet, M.D. was board certified in general psychiatry and addiction medicine. Eileen Farber, M.D. was board eligible in general psychiatry. Ernest Kendrick, M.D. was board certified in general psychiatry, child and adolescent psychiatry, and forensic psychiatry. Experience All of the psychiatrists currently providing services at the facility had experience in providing care to individuals with developmental disabilities. Monitoring Team's Compliance Rating J1 was in substantial compliance due to psychiatric services being provided only by persons who were qualified professionals. Since the last review, the facility retained the services of psychiatrists with specialized training in child and adolescent psychiatry. To maintain substantial compliance, 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.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Number of Individuals Evaluated At MSSLC, 251 of the 295 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 four psychiatry clinics during the monitoring review. It was apparent that the team members attending the clinic were well meaning and interested in the treatment of the individual. The quarterly psychiatric evaluations were well organized and there was good discussion and documentation of the individual's history and presenting symptoms. The facility designed a system of typed documentation, updated during the quarterly evaluation (or as clinically indicated), as opposed to each psychiatrist handwriting all of the information numerous times. Even so, some of the psychiatrists clearly had difficulty multitasking (e.g., managing the clinic, reviewing the data presented, typing the information received). The difficulties that psychiatric staff were experiencing with documentation were also evident during a review of completed psychiatric paperwork. For example, between 12/1/13 and 5/31/14, three of	Noncompliance

#	Provision	Assessment of Status	Compliance
		the five psychiatrists providing services at the facility were delinquent in completing documentation. One physician had completed 45% of the required documentation (156 total clinical encounters, 70 documentations submitted), another physician had completed 26% of the required documentation (23 total clinical encounters, six documentations completed), and a third physician had completed 44% of the required documentation (205 total clinical encounters 91 documentations completed). This process needs to be further reviewed to find ways for staff to support the psychiatrists during the clinic to accomplish these tasks in a reasonable amount of time. The psychiatry department now had two psychiatric assistants, a psychiatric clerk, and a nurse compliance monitor. The medical director and lead psychiatrist should review how staff could better assist the psychiatrists. Some suggestions are below. • 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 between November 2013 and April 2014, on average, 89% of the QPMRs were done within 90 days and 96% of the Appendix B evaluations were 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. There were challenges with these data, however, because while the clinics were held in a timely manner, there were unacceptable delays with regard to completion of physician documentation. The facility provided a self-rating of substantial compliance for this provision item and the monitoring team disagreed based on the lack of documentation. <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. <u>Monitoring Team's Compliance Rating</u> Although the psychiatry staff were performing adequately with regard to the required	

#	Provision	Assessment of Status	Compliance
		clinical encounters, there were serious deficits with regard to the completion of documentation. Thus, it was not possible to ensure that the individuals prescribed psychotropic medication were evaluated and diagnosed as required by this provision. In order to achieve substantial compliance with this provision, physician documentation must be submitted in a timely manner.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	<u>Treatment Program/Psychiatric Diagnosis</u> Per this provision item, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medications in lieu of a treatment plan or in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis. For the majority of individuals prescribed medication, there was a diagnosis cited in the record. The 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.). The inconsistency of diagnoses was likely due to the frequent transfer of individuals to different psychiatric caseloads. While it is understood that this will occur due to physician attrition, there were also frequent changes due to individuals moving from home to home. It would be beneficial for individuals to maintain one provider regardless of their residence. 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 individuals prescribed medication had diagnoses noted in the record, there were concerns regarding the lack of clinical indicators identified for psychotropic medications. It is important for collaboration to occur between behavioral health 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 is essential that this information be documented in the individual's record in a timely manner. <u>Emergency use of psychotropic medications</u>: The monitoring team was provided information during the onsite visit that there were two chemical restraints during this monitoring period. This was a reduction from 14 during the previous period. The self-assessment summarized that the facility reviewed both of these chemical restraint episodes to determine if documentation supported that medications	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. Furthermore, the self-assessment noted that only one of these episodes resulted in an emergency psychiatry clinic within 24 hours of the event. The monitoring team agreed with these self-assessment findings. Per discussions with facility staff, there was some confusion regarding the use of the designation of PEMA (psychiatric emergency medication administration). Currently, the facility was not utilizing this designation, and had made the decision that if emergency medications were administered, they would be treated as a chemical restraint in order to ensure all the protections and monitoring requirements. This designation should be clarified by DADS in order to avoid confusion and different monitoring between facilities. <u>Monitoring Team's Compliance Rating</u> The facility provided a self-rating of noncompliance and the monitoring team agreed with this rating due to inconsistent integration between psychiatry and the IDT regarding treatment planning, nonpharmacological interventions, and behavioral support planning. The facility had done a nice job with regard to the minimal utilization of chemical restraints.	
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.	<u>Extent of Pretreatment Sedation</u> The facility's documents indicated there was one administration of pretreatment sedation at MSSLC for the past six months. It was documented that Individual #310 received pretreatment sedation for a medical procedure. The IDT determined a desensitization program should be developed for this individual. Note, however, that data discussed above did not include pretreatment sedation that was given for dental or medical purposes at any <u>offsite</u> facilities. Additional data received revealed that between 11/6/13 and 4/14/14 there were 30 episodes of pretreatment sedation occurring off campus. Of these, 22 were sedations for medical purposes and eight were for dental procedures. Of these 30 individuals, 25 were participating in psychiatry clinic and were prescribed psychotropic medication. Per staff interviews, all pretreatment sedations were reviewed during MRC. This process was outlined via the "Pre-treatment sedation protocol" which was effective as of 2/1/12. Documentation regarding this process was provided for review and included the individual's name and the reason for the planned sedation. The document did not include the details of the discussion or recommendations. The monitoring team observed this process during the MRC meeting on 6/5/14. The staff were noted to make adjustments to the individual's medication regimen to allow for sedation, however, this was limited because the facility staff were not aware of what mediations were planned for use off campus.	Noncompliance

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		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 free the facility of its responsibility to log, cite, and monitor individuals who received pretreatment sedation and then returned to MSSLC. There was useful material discussed in an interdisciplinary fashion in both the MRC and desensitization committee. The pretreatment sedation protocol effective 2/1/12 indicated that all non-emergent cases of pretreatment sedation were submitted to MRC for approval where the primary care physician, pharmacist, nursing representative, and psychiatrist were present. The psychologist assigned to the individual's treatment discussed 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, 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 should 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).	

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		Monitoring After Pretreatment Sedation There were 10 examples provided for this section and, in all cases, appropriate monitoring was documented. The facility must monitor individuals who have received pretreatment sedation elsewhere and then returned to MSSLC on the same date because of the possible synergistic activity and/or drug-drug interactions (between these agents and the routine medications prescribed). The facility needed to be aware of 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). Per the facility self-assessment, 100% of the records of individual's receiving pretreatment sedation during this period were reviewed and revealed appropriate nursing monitoring during the post sedation period. Desensitization Protocols and Other Strategies A list of all individuals with medical/dental desensitization plans and date of implementation were requested. There were a total of four individuals documented as having dental desensitization plans (Individual #484, Individual #500, Individual #492, and Individual #1). All of these examples were dated prior to the current monitoring period. 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. Per the facility self-assessment, in 30 records reviewed, 86% included an ISP that included recommendations for treatments or strategies to minimize or eliminate the need for pretreatment sedation. It was notable that the dental clinic staff had continued with informal desensitization. This included meeting with individuals a number of times in order to increase their comfort level with both the clinic and clinic staff. The facility dental clinic staff described a process they were utilizing for Individual #732. The dental clinic staff were attempting to clean this individual's teeth. Initially he allowed only one tooth to be cleaned, but over time, had increased the number of teeth addressed. Dental staff stated, "We are working at his pace, not ours." See section Q for review of the overall provision of dental services. Monitoring Team's Compliance Rating 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	

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		pretreatment sedation upon the individual's return to MSSLC. The facility provided a rating of noncompliance for this provision, and the monitoring team 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 85% of the census received psychopharmacological intervention requiring psychiatric services at MSSLC as of 6/2/14 (a total of 251 individuals). Of these, 49 individuals were age 18 or younger. There were a total of five FTE psychiatrists at MSSLC. The lead psychiatrist, appointed 2/3/12, was an employee of the facility and had the responsibility of managing approximately 20% of the clinical caseload in addition to addressing the provision items in provision J. The additional full-time equivalent psychiatrists had appropriate and similar caseloads (e.g., 18% - 24% of individuals who required psychiatric services). These psychiatrists were obtained via a locum tenens company. Given the turnover inherent in locum tenens providers, the facility had developed a "pearls of wisdom" book for the physicians to review in order familiarize themselves with the facility, paperwork requirements, and specifics of practice in a SSLC. This was good to see. The monitoring team suggests that it can be improved further with some specification of how working in an SSLC and as a member of the IDTs differs from other types of psychiatric practice. 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 in addition to psychiatry clinic, each psychiatrist should attend ISPs, ISPAs, Polypharmacy Meetings, MRC, Pharmacy and Therapeutics, and other various meetings. The lead psychiatrist also attended the PET and QA/QI meetings. <u>Administrative Support</u> There were two designated full-time psychiatric assistants, Ms. Virginia Jackson and Ms. Bobbie Hall. They provided administrative support to the psychiatrists for scheduling evaluations, obtaining records and contact information, and other duties related to the coordination of psychiatric services, such as collection of pertinent data. There was 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.). As of March 2014, Ms. Anita Brewer had joined the psychiatry clinic team as the psychiatry clerk. Her responsibilities included preparing documents in advance of psychiatry clinic and scheduling appointments. <u>Determination of Required FTEs</u> MSSLC had done an adequate job in assessing the amount of psychiatric FTEs required. The number of hours required for the provision of psychiatric services were calculated to include not only clinical responsibility, but also documentation of delivered care such as	Substantial Compliance

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		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 rated in 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 96% of the individuals receiving psychiatric services had an Appendix B evaluation completed. In addition, for individuals newly admitted to the facility, data indicated that 73% were seen by psychiatry and completed within the appropriate time limits. Appendix B style evaluations were reviewed for the following nine individuals: Individual #703, Individual #629, Individual #113, Individual #961, Individual #799, Individual #937, Individual #872, Individual #871, and Individual #745. All Appendix B evaluations included case conceptualizations and history that reviewed information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. 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 some variability in documentation. Below are comments from the monitoring team. • The case formulation should include a review of the symptoms and diagnostic criteria met that allowed for a particular diagnosis. • 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.	Substantial Compliance

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		• 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 and timeliness. <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 Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	<u>Reiss Screen Upon Admission</u> The Reiss screen, an instrument used to screen each individual for possible psychiatric disorders, was to be administered upon admission, and for those already at MSSLC, only for those who did not have a current psychiatric assessment, 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 21 new admissions since 1/1/14. The director of the behavioral health services 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. <u>Reiss Screen for Change in Status</u> Staff interviews performed during this monitoring visit revealed that in the intervening period since the last monitoring visit, the Reiss Screen was utilized on two occasions in order to assess individuals following a change in status. 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. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> Per interview with the behavioral health services director, all individuals 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	Substantial Compliance

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		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 the monitoring team agreed. Further, the Reiss Screen had been utilized to assess change in status.	
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. Interdisciplinary Collaboration Efforts In order to address this provision item, the facility had instituted psychiatry/behavioral health integration forum. The monitoring team attended the psychiatry/behavioral health integration meeting on 6/5/14. During the monitoring visit, it was reported that there remained challenges in the relationship between behavioral health 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. 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, behavioral health, nursing, QIDP, direct care professional, and the individual). Medication decisions made during clinic	Noncompliance

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		observations conducted during this onsite review were based on relatively long (minimum 30 minute) observations/interactions with the individuals, as well as review of information provided during the time of the clinic. The psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress with them, and discussed the plan, if any, for changes to the medication regimen. An IDT process (i.e., ISPA) essentially occurred within the psychiatry clinic, with representatives from various disciplines participating. <u>Integration of treatment efforts between psychology and psychiatry</u> Behavioral health 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 behavioral health did not consistently provide data of the essential <u>target symptoms</u> that were deemed necessary for monitoring 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 focused predominantly on behavioral presentation, such as aggression and SIB. Collaboration should be evident in psychiatry clinic, psychiatric treatment plan, psychiatric assessment, nursing assessment, Active Problem List, the ISP process, the PBSP process, and 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 behavioral health 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. Further, 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 sequential tasks, undertaken to channel distinct disciplinary assessments into the creation of an integrated treatment plan. These tasks should include review and integration of information from assessments performed by the various disciplines, identification of factors (i.e., as outlined per Appendix B including biological, psychological, social, and spiritual), creation of clinically based expectations	

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		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 behavioral health focused on variables (i.e., behavioral problems/SIB) instead of also looking at psychiatric target symptoms to determine medication efficacy pertinent to the established diagnosis. 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 behavioral health 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, individuals have consistency in their psychiatric physician. At MSSLC, if an individual moved to a different home, he or she 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 to do. <u>Monitoring Team's Compliance Rating</u> The monitoring team agreed with the facility's rating of noncompliance for this provision item. The monitoring team's decision was based on the issues cited in the report, such as paucity of cohesive combined assessment and case formulation across disciplines.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including	<u>Psychiatry Participation in PBSP</u> During 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. The facility now incorporated a review of the PBSP during the third QPMR conducted with members of the IDT present. Per the facility self-assessment, of 24 QPMRs between the dates of 10/1/13 to 3/31/14, 20 (83%) documented discussion of the PBSP during the third QPMR. The psychiatrist did not, however, sign the completed document.	Noncompliance

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	the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	The MSSLC PBSP does not have a signature line for the collaborating psychiatrist. The psychiatrists elected to no longer attend the BTC process because this type of information was now being reviewed in the third QPMR. This forum was deemed to be the appropriate place to determine the least intrusive and most positive interventions for the individuals' care. In order to meet the requirements of this provision item, there needs to be evidence that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item, and that the required elements are included in the document. <u>Treatment via Behavioral, Pharmacology, or other Interventions</u> It was warranted for the treating psychiatrist to participate in the formulation of the behavior support plan via providing input or collaborating with the author of the plan. This provision item focuses on the least intrusive and most positive interventions to address the individual's condition (i.e., behavioral or psychiatric) in order to decrease the reliance on psychotropic medication. The monitoring team attended the psychiatry/behavioral health meeting. There was frustration noted on the part of both behavioral health 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 monitoring visit, it was reported that the psychiatric support plan (PSP) process had been implemented, with eight individuals having PSPs. <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. Data revealed that psychiatry attended 13% of the ISP meetings for individuals followed by psychiatry clinic between the dates of 12/3/13 and 5/29/14. The facility had begun tracking IRRF submissions, and reported that 61% of these were delinquent. It is imperative that psychiatry is an active part of the ISP process inclusive of the timely submission of IRRF and attending the ISP meetings. <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' inadequate involvement in the ISP process. It would be helpful in future monitoring reviews for the psychiatry department to indicate <u>where</u> reviews (e.g., of the PBSP) were documented in the record and to provide the <u>names</u> of those individuals who were reviewed, so that a sample of these records can be requested.	

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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 requires 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. A review of 15 records revealed marked disparities in the quality of case formulations and risk benefit analysis. For example, in the record of Individual #703, the psychiatrist did an excellent review of a diagnosed genetic disorder, including a description of the physical anomalies and potential heath sequelae. This individual was also diagnosed with a mood disorder and a thought disorder. Neither of these diagnoses, however, were addressed in the case formulation. The associated risk benefit analysis for treatment with psychotropic medications was brief and formulaic, "risks of not treating…are the psychiatric symptoms which lead to his impulsive acting out behaviors…endangerment of self and others. These risks outweigh the risks of the side effects from his medications." In contrast, the risk benefit analysis documented for Individual #852 was both detailed and descriptive. "…on this class of medications for a long time…beneficial by preventing him from experiencing…more serious psychotic symptoms…continues to have paranoia, delusions…tolerating Risperdal well…glucose and lipids…normal…proposed switch to Invega…meant to likely increase efficacy with possibly no appreciable change…of side effect	Noncompliance

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		load…prescribed to treat his psychotic symptoms…thereby reduce risk of harm to self and others and support the goals of increasing psychosocial growth and social competencies…benefits…clearly outweigh the risks…risks…include worsening of thought disorder…increased risk of harming self and others. If his symptoms and maladaptive behaviors worsen, then his ability to learn functional behaviors and methods of better communicating his needs and preferences would likely be markedly reduced…there is a clear clinical indication and advantage to utilizing psychotropic medications…" The document also included a discussion or specific risks associated with each prescribed medication. 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. 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 diagnostics varied among the disciplines and among psychiatrists. Review of individual records revealed that individuals continued to move from psychiatrist to psychiatrist. 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. It was considered that some of the challenges with diagnostic concordance and risk benefit analysis were directly related to delinquencies in psychiatric documentation. Data presented indicated that for the period of 12/1/13 though 5/31/14 psychiatric physicians had submitted only 61.6% of clinical documentation. There was a wide range of completion as two psychiatrists were current (100% complete and 93% complete). The remaining three psychiatrists had significant deficiencies (44% complete, 45% complete, and 26% complete). These delays in the completion of clinical documentation must be addressed. 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	

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		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. Observation of Psychiatric Clinic 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 in some observations that the psychiatrist struggled with completing multiple tasks simultaneously including typing relevant information while reviewing the record and attempting to interview the individual. The QIDP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this section. Recommendations include accomplishing this goal together with the IDT by holding lengthier clinics (e.g., 45-60 minute, individual consult). Of course, for the initial entry in the documentation, some prep time would be necessary to set up the shell of the document. 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 regard 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 self-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. The information must then be documented in a timely manner.	

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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 use of psychotropic medications was clinically justified, and that medications that were not clinically justified were eliminated. The polypharmacy meeting was observed during the monitoring visit on 6/2/14. During this meeting, five individual's regimens were reviewed. In some cases, individuals will require polypharmacy and treatment with multiple medications that may be absolutely appropriate and indicated. The prescriber must 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. While the polypharmacy meeting observed during this monitoring visit did not demonstrate a brisk discussion regarding the individual's regimen, this element was located in the review of minutes of previous meetings. It was noted that the existing facility level review process was structured, included preparation regarding the individual's case history, and afforded the opportunity for a peer review process whereby other psychiatrists could question the prescribing physician about the rationale for the use of medication and diagnostics. Review of Polypharmacy Data The results of the June 2014 data indicated the following: • There were 104 individuals prescribed polypharmacy; • There were 259 individuals prescribed psychoactive medications; • 40.2% polypharmacy cases; • One individual was prescribed eight psychotropic medications; • Eight individuals received five medications; • 25 individuals received four medications; • 67 individuals received three psychotropic medications; • 101 individuals were classified in the intraclass within polypharmacy category; this was an increase from 26 individuals classified in the previous monitoring review. • Three individuals received "Pure Intraclass" of two medications Overall, data were lacking in that it was not possible to determine what medications were prescribed that resulted in the designation of interclass polypharmacy. There had been a 200% increase in intraclass polypharmacy in the intervening period since the previous monitoring review. It was not possible to determine the reason for this increase.	Noncompliance

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		Review of Polypharmacy Justifications 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 utilization of psychotropic medications, specifically polypharmacy. 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 important. Monitoring Team's Compliance Rating 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. There are concerns regarding the marked increase in individual's prescribed intraclass polypharmacy, and these data must be explained. Given the marked increase in intraclass polypharmacy in the absence of justification, this provision item will remain in noncompliance.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS) The facility self-assessment noted that 97% 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 6/5/14 did not include a review of this provision. The facility self-assessment further stated that per a review of MOSES and DISCUS assessments completed between 10/1/13 and 3/31/14, 93% of the instruments were completed and signed in a timely manner. The facility provided information regarding scores and dates of completion of evaluations dated November 2013 through April 2014. 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 in order to determine the timely completion of the instruments because data were not sequential. A revision in the presentation of data into a spreadsheet may assist with tracking both the completion of the instruments over time and changes in scores prompting further clinical evaluation. 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	Noncompliance

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		may be helpful to identify reasons for the deficiencies (i.e., individual was discharged from the facility or no longer received psychotropic medication). These types of data can aid the facility with self-assessment ratings indicating compliance with the requirements of this provision. <u>Training</u> Data received indicated that 25 nurse case managers attended the annual training for the MOSES and DISCUS. Three nurse case managers were scheduled to complete training in June 2014. <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 assessments were entered into Avatar. In four examples, the psychiatrist had completed the clinical correlation and electronic signature via Avatar. In the other six examples, the psychiatrist had handwritten his or her review and signature on the printed form. In all examples, the psychiatrist's review was performed within a week of completion of the assessment. Fourteen individuals were noted to have the diagnosis of Tardive Dyskinesia (TD). This was an increase from nine 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 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. Motoric movements caused by cerebral palsy would not warrant TD diagnosis unless otherwise indicated. There were 30 individuals residing at the facility who were edentulous. <u>Implementation of Avatar</u> The facility had implemented the Avatar system. This was an electronic database where information, including MOSES and DISCUS results, can be stored. Since the last monitoring visit, the Avatar system had been updated, allowing for documentation of the clinical review of the examination, and for an electronic signature of the reviewer.	

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		Per staff interview, the Avatar interface for electronic completion of MOSES and DISCUS assessments was both challenging and time consuming. As such, the facility was maintaining both an electronic and paper copy of the instruments. A review of the QPMR documentation associated with the completed scales revealed that in all cases the scores were documented in the clinic note. Monitoring Team's Compliance Rating 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 is completed. Due to the challenges with the Avatar interface, 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 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	Policy and Procedure Per a review of the DADS statewide policy and procedure "Psychiatry Services," effective 8/30/11, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." In section 7.b, the policy reflected the language in this provision item. The facility had implemented a facility specific policy and procedure "Psychiatry Services" dated 7/1/13 that reiterated the need for integrated clinical services, however, the document did not delineate a specific procedure by which this would occur. Treatment Plan for the Psychotropic Medication 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. As noted above, there were challenges with regard to the timely submission of completed psychiatric documentation (see J2). 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	Noncompliance

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	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.	reliability of data, and 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 behavior in order to assess the treatment's efficacy. Examples of QPMRs in the electronic format were provided to the monitoring team. There was varying quality of the documentation noted. One example, regarding Individual #916, included information regarding this individual's most recent mental health symptoms. 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. <u>Psychiatry Participation in ISP Meetings</u> There was minimal psychiatry participation in the ISP process since last review (addressed in J9). The facility had a full complement of psychiatrists that allowed for their participation in the ISP/ISPA meetings. In an effort to utilize staff resources most effectively, the facility incorporated some components of the IDT meetings into the third QPMRs. Given the interdisciplinary model utilized during psychiatry clinic, the integration of the IDT in psychiatry clinic may allow for improvements in overall team cohesion, information sharing, collaborative case conceptualization, and management. <u>Frequency of Consultation with the Psychiatrist</u> The two full time psychiatric assistants who coordinated the psychiatrists' schedules and the clinic management informed the monitoring team that individuals were to be seen in clinic at a minimum of once per quarter for their quarterly medication review. Data were via the QA/QI council indicated improvements with timeliness of QPMR. Between November 2013 and April 2014 86% of the clinics occurred in a timely manner. There was a range of 70% (in November 2013) to 92% (in December 2013). <u>Psychiatry Clinic</u> During the monitoring review, four psychiatry clinics were observed. The monitoring team observed a psychiatry clinic conducted by four of the five facility psychiatrists. In addition, neuropsychiatry clinic was observed during this monitoring review (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	

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		(i.e., minimum of 15 minutes) with the individual and discussing the psychotropic medication 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. <u>Medication Management and Changes</u> The 90-day reviews of psychotropic medication must include medication treatment plans that outline a justification for a diagnosis, a thoughtful planned approach to psychopharmacological interventions, and the monitoring of specific clinical indicators to determine the efficacy of the prescribed medication. Dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response via a clinical encounter with the individual and a review of appropriate target data (both pre and post medication adjustment), the physician can determine the benefit, or lack thereof, of each medication adjustment. There were some improvements noted regarding exchange of pertinent information during some of the psychiatric clinics, however, the data predominantly focused on behavioral presentation (e.g., self-injurious behavior or aggression towards others). This information, although relevant, was insufficient if the goal was to implement an evidence-based approach in evaluating medication efficacy associated with a psychiatric disorder. There are some psychiatric disorders, such as autistic disorder, where 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 behavioral health services staff that improved integration of their departments will be necessary in order to meet the	

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		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. Monitoring Team's Compliance Rating The monitoring team agreed with the facility's rating of noncompliance. A review of 15 records revealed varying quality in documentation for the psychiatric reviews. In addition, as discussed in J2, there were significant delinquencies in the completion of psychiatric documentation. 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 current status and/or changing needs.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the 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 the responsible party for obtaining informed consent for any new psychotropic medications. Psychiatrists were also responsible for annual re-consent for psychotropic medications. Per the facility self-assessment, 30 individual active records were reviewed to ensure appropriate informed consent prior to the administration of nonemergency psychotropic medications. It was reported that 93% of the records reviewed revealed appropriate informed consent. The self-assessment also indicated that of the informed consent documents completed between 10/1/13 and 3/31/14, 95% included the required documentation. The self-assessment did not indicate the number of examples reviewed for	Substantial Compliance

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		this metric. Additional data regarding the annual re-consent process were reviewed. These data were presented at the QA/QI council meeting 6/5/14. It was noted that the facility had began tracking these data in July 2013. At that time, 59% of the annual re-consent documents due for that month were delinquent. These data have improved somewhat over time: • January 2014 - 39% were delinquent • February 2014 - 20% were delinquent • March 2014 - 4% were delinquent • April 2014 – 20% were delinquent • May 2014 – 2% were delinquent Interviews with facility staff revealed that efforts to improve these data included providing each psychiatrist with a list of annual re-consents due/overdue each week. 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 six 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. This was an issue reported in the previous monitoring report where seven of 10 examples did not include the designation. This documentation deficit must be addressed. 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. To summarize, current facility practice was 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.	

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		Monitoring Team's Compliance Rating The monitoring team agreed with the facility's rating of substantial compliance. The psychiatry department was obtaining informed consent for the initiation of new psychotropic medications and performing annual re-consent. The facility must ensure that facility policy and procedure is consistent with statewide policy. In order to maintain this substantial compliance rating, the facility must improve with regard to the 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.	Policy and Procedure 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 included language from the Settlement Agreement regarding this requirement. The policy did not delineate a procedure via which this process would occur. Individuals with Seizure Disorder Enrolled in Psychiatry Clinic The monitoring team received a numbered alphabetized list of 62 individuals participating in psychiatry clinic who had a diagnosis of a seizure disorder. This was identical to the number of individuals identified during the previous visit. Adequacy of Current Neurology Resources The record request for the schedule of the consulting neurologist noted the neurologist came to MSSLC approximately once a month for Neuro-Psych clinic. Clinic dates submitted to the monitoring team began in November 2013, though none were provided for January 2014. There were two clinics in March 2014, and one clinic observed during this monitoring visit. Per interviews with facility staff, neurology resources remained stable at 16 hours per month. Review of data regarding the last clinical consultation for individuals requiring neuro-psychiatric consultation revealed that of 62 individuals, two had not been seen in clinic in the previous year. But, of the two individuals who had not been seen in the previous 12 months, Individual #745 was recently admitted to the facility. Individual #119 had no dates of "Neuro-Psych" review indicated. This individual was documented as having a diagnosis of Tardive Dyskinesia. In the previous review, 14 individuals had not been seen in the previous year. Thus, the facility made strides with regard to ensuring that individuals were scheduled for Neuro-Psych consultation. The facility must ensure that all individuals requiring Neuro-Psych consultation are scheduled for clinic in a timely manner. It was noted that the facility had created a spreadsheet for tracking Neuro-Psych clinic that	Substantial Compliance

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		included the date for the individual's upcoming annual consultation. Some of the individuals were evaluated by outside providers for neurological care (e.g., Scott and White medical center physicians). Since the last monitoring report, there was consistency with regard to neurology consultative resources. It was reported, documentation supported, and it was observed that Neuro-Psych consultation included the neurologist meeting with the IDT inclusive of the psychiatrist to review the neurology clinical consultation and to collaborate with regard to recommendations and future treatment. Although there was a requirement for this consultation in policy and procedure, there were no policy or procedure detailing this practice. The neuropsychiatric evaluation can be one of the QPMRs if completed satisfactorily with the psychiatrist, neurologist, and the IDT. These are the type of processes that the lead psychiatrist and medical director should consider in order to reduce redundant activities. The drug regimen and drug interactions require a thorough review, particularly for individuals with intractable epilepsy, and how these variables affect the mental status presentation. During this monitoring visit, three interactions between the neurologist, psychiatrist, and IDT were observed. These interactions were variable with regard to quality. In one interaction, the IDT was noted to talk over the neurologist, failing to obtain information regarding the consultation. In another interaction, the psychiatrist did not utilize the neurologist's time adequately, instead discussing issues with the individual that did not require neurology input, spending only two minutes discussing the neurological issues. In contrast, during the third interaction, the psychiatrist and the IDT were obviously well prepared for the neurology consultation. When the neurologist entered the meeting, the psychiatrist asked the neurologist to present his findings, asked appropriate questions regarding the individual's treatment, and the ongoing course of treatment including laboratory examinations, potential medication regimen adjustments, and neurology follow-up. There were opportunities for the IDT and the individual to ask questions. This was an excellent use of the neurology consultation resource and should be modeled for other IDT meetings. <u>Monitoring Team's Compliance Rating</u> The neurologist and psychiatrist must coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	

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		The facility had continued the process of neuro-psychiatric consultation that began in November 2013, however, there were no policy or procedural documents outlining the requirements for this process. These must be developed. The monitoring team recommends that the psychiatry department develop an outline for this consultation. This could be included in policy and procedure.	

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Functional Assessments for: • Individual #143 (2/13/14), Individual #441 (11/6/13), Individual #393 (11/1/13), Individual #107 (11/25/13), Individual #195 (12/16/13), Individual #154 (12/20/13), Individual #233 (12/30/13), Individual #451 (1/27/14), Individual #157 (4/6/14), Individual #466 (4/7/13) o Positive Behavior Support plan (PBSP) for: • Individual #143 (3/10/14), Individual #441 (12/6/13), Individual #293 (12/1/13), Individual #475 (12/12/13), Individual #393 (12/23/13), Individual #107 (1/28/14), Individual #195 (1/29/14), Individual #154 (2/3/14), Individual #233 (2/20/14), Individual #451 (2/25/14), Individual #242 (5/12/14), Individual #157 (4/10/14), Individual #284 (4/3/14), Individual #466 (3/5/14), 324 (5/1/14), Individual #414 (5/18/14) o Progress notes for: • Individual #143, Individual #441, Individual #293, Individual #475, Individual #393, Individual #107, Individual #195, Individual #154, Individual #233, Individual #451 o Annual Psychological Assessments for: • Individual #329 (11/15/13), Individual #476 (11/21/13), Individual #107 (12/20/13), Individual #164 (1/10/14), Individual #429 (1/13/14), Individual #504 (1/13/14), Individual #153 (1/23/14), Individual #798 (3/7/14), Individual #605 (3/24/14), Individual #373 (3/25/14) o Full Psychological Assessments for: • Individual #962 (1/15/14), Individual #603 (2/15/14), Individual #278 (3/31/14), Individual #736 (3/6/14), Individual #659 (3/6/14), Individual #784 (3/12/14), Individual #696 (3/13/14), Individual #697 (4/3/14), Individual #937 (4/10/14), Individual #872 (4/14/14) o Individual Support Plans (ISPs) for: • Individual #120, Individual #143, Individual #195, Individual #233, Individual #659,Individual #816, Individual #451, Individual #98, Individual #211, Individual #989 o Section K Presentation Book, undated o Section K self-assessment, 5/9/14 o Psychology/Psychiatry meeting agenda, 6/5/14 o Section K Action Plan, 5/1/14 o Current census count by home, 6/2/14 o Competency based training sheet, undated o Evaluation of Psychological Interventions and Monitoring, 2/27/14

	○ Data collection timeliness, IOA, and treatment integrity data for Longhorn and Shamrock for 12/13-May/14 ○ Data collection timeliness, IOA, and treatment integrity data for Whiterock for 2/14-5/14 ○ Data collection timeliness, IOA, and treatment integrity data for Barnett for 4/14 and 5/14 ○ List of dates of psychological assessments for all individuals, undated ○ Minutes from psychology department meetings for the past six months ○ List of all individuals with a PBSP, undated ○ A list of training conducted on PBSPs, undated ○ Section K PET progress report, dated 6/4/14 ○ Peer review minutes from 11/13 to 4/14 <u>Interviews and Meetings Held</u>: ○ Charlotte Kimmel, Ph.D., Director of Behavioral Health ○ Lupita Alfaro, Psychology Assistant ○ Behavioral Health Department ○ Andrew Griffin, Ph.D., Forensic Psychologist ○ Jennifer Sanchez, Doctoral Intern; Christine DiRubbo, Doctoral Intern <u>Observations Conducted</u>: ○ PET meeting ○ Clinical Psychology/Psychiatry Meeting ○ Internal Peer Review Meeting • Individuals discussed: Individual #320, Individual #557, Individual #177, Individual #381 ○ Psychiatric Clinic • Psychiatrist: Dr. Kendrick • Individual presented: Individual #539 ○ Positive Behavior Support Plan Training • PBSP for: Individual #385 • Staff conducting the training: Heather Brooks, Behavior Health Specialist; Ora Davis, Behavior Analyst ○ Data Project Presentation ○ Behavior Therapy Committee Meeting: • Individuals reviewed: Individual #997, Individual #284, Individual #69, Individual #10 ○ 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.
	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, and demonstrated improvements in several additional items. These improvements since the last review included: • Increase in the flexibility of the data collection system (K4) • Improvement in data collection timeliness (K4) • Improved evidence of data-based treatment decisions (K4) • Establishment of goal frequencies of data collection timeliness, IOA, and treatment integrity (K4, K10) • 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 a current annual psychological assessment (K7) • Increase in the quality of Positive Behavior Support Plans (PBSPs) (K9) • Increase in the percentage of PBSPs that were consistently implemented within 14 days of receiving necessary consent (K9) The monitoring team suggests that MSSLC focus on the following areas during the next six months: • Track data collection timeliness and IOA frequency data (K4) • Expand the collection of data timeliness measures, interobserver agreement (IOA), and treatment integrity to all individuals with a PBSP (K4, K10) • Demonstrate that the established frequencies and levels of data timeless, IOA, and treatment integrity are achieved (K4, K10)

	• Increase the percentage of individuals with a full psychological assessment (K5) • 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)

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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 (14%) of the 14 staff that wrote PBSPs were BCBAs. This is the same number of BCBAs reported in the last review. Additionally, nine of 14 staff that wrote PBSPs (64%) were either enrolled, or completed coursework, toward attaining a BCBA. This was a decrease from the last review when 73% 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. MSSLC provided supervision of psychologists enrolled in the BCBA program by contracting with a consulting BCBA from the community. 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 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
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	MSSLC continued its weekly internal, and monthly external, peer review meetings. The internal peer review meetings provided an opportunity for staff to present new cases or those that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #320, Individual #557, Individual #177, and Individual #381. Individual #557's	Substantial Compliance

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		functional assessment was reviewed which resulted in a discussion of the use of a PBSP or psychiatric support plan to best address his behavioral issues. Additionally, for all of the individuals discussed in peer review, there was active participation from the department's behavioral health specialists that appeared to result in the identification of several potentially useful strategies to address each individual's target behaviors. Review of the minutes from internal peer review meetings indicated that the majority of staff that wrote PBSPs regularly attended peer review meetings. Additionally, meeting minutes from the last six months indicated that internal peer review meetings occurred in 22 of the last 25 weeks (88%), and that once in each of the last six months, these meetings included a participant from outside the facility, therefore, achieving the requirement of monthly external peer review meetings. Finally, there was evidence of the implementation of recommendations made in peer review. Operating procedures for both internal and external peer review committees were established, and were consistent with this provision item. In order to maintain substantial compliance, MSSLC needs to provide documentation that internal peer review occurs during at least 80% of the weeks reviewed, external peer review occurs during at least 80% of the months reviewed, and there is evidence of follow-up/implementation of recommendations made in peer review.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have	MSSLC continued to make steady progress in this area. More work, discussed in detail below, is necessary before this provision item can be judged to be in substantial compliance. During the last review, 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 (i.e., Longhorn and Shamrock). Since the last review MSSLC expanded its new, more flexible data system to two additional units (Whiterock and Barnett). Additionally, the facility continued to expand the flexibility of the data system by including duration measures. It is recommended that MSSLC continue to expand the data system to all treatment sites on campus. In the current data system, 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 timeliness).	Noncompliance

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	substantially changed.	As in past reviews, the monitoring team did its own data collection timeliness review 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 10 of 12 data sheets reviewed (83%) were completed up to the previous hour. These results were sharply higher than those reported in last two reviews (i.e., 69%, 64%). This percentage was above MSSLC's established minimal acceptable level (80%), and consistent with the facility's available data collection timeliness results (77%). These improvements are likely due to data collection timeliness being expanded to four of the five units at MSSSLC. Additionally, the facility recently established that data collection timeless would be collected at least quarterly for all individuals with a PBSP. At the time of the onsite review, there were no data available indicating the frequency of data collection timeless. At this point it is recommended that that MSSLC expand the collection of data timeliness measures to all treatment sites, and ensure that the established goal frequency of data collection timeliness measures and minimal acceptable level are achieved. While data collection timeliness measures assess 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 expansion of the collection of IOA data from two to four units, and the establishment of minimal acceptable frequency of IOA collection (i.e., quarterly for each individual). Available facility IOA data indicated that IOA averaged 72% across the units collecting IOA data, which was slightly below the facility goal level of 80%. There were no data available indicating the frequency of data collection timeliness. It is recommended that that MSSLC expand the collection of IOA to all treatment sites, and ensure that the established goal frequency of IOA and minimal acceptable level are achieved. 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 also improved since the last review. In a psychiatric clinic for Individual #539 that was 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 #539's treatment team, and to data based decisions concerning his future	

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		course of treatment. Six months of PBSP progress notes were requested and, as reported in the last review, all (100%) had monthly progress notes. In reviewing at least six months of PBSP data of severe behavior (e.g., physical aggression, self-injurious behavior) for 16 individuals, eight, or 50%, indicated no obvious improvement in severe behavior. This represented a decrease from the last review when 33% of the individual's reviewed showed no obvious improvement in severe behavior. For one (Individual #451) of those individuals, the progress notes indicated clear 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 progress 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 to all units. Additionally, the facility needs to track data collection timeliness and IOA frequency data, and ensure that goal frequency and levels are achieved.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of full psychological assessments for each individual, 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 presented to the monitoring team indicated that 161 of the 295 individuals at the facility had a full psychological assessment. Thirteen of the 295 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 161 full psychological assessments for the 282 individuals who had been at MSSLC for at least three months (57%). This was a decrease	Noncompliance

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		from the last review when 66% of the individuals at the facility at least three months had a full psychological assessment. 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. The spreadsheet of full psychological assessments indicated that 23 were completed in the last six months, and 10 of these (43%) were reviewed to assess compliance with this provision item. All 10 of the full psychological assessments reviewed (100%) were judged 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 an increase from the last review when 90% of the full assessments reviewed were complete. <u>Functional Assessments</u> A spreadsheet provided to the monitoring team indicated that 66 of the 250 individuals with a PBSP (26%) had a current (i.e., reviewed/revised in the last 12 months) functional assessment. This was consistent with the last review when 23% of individuals with a PBSP 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. The spreadsheet provided to the monitoring team indicated that 33 functional assessments were completed in the last six months. Ten of those functional assessments (30%) 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 target 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 10 functional assessments reviewed (100%) included acceptable indirect and direct assessment procedures. This was 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 was consistent with the last three reports when all functional assessments included potential antecedents and consequences.	

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		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. Overall, all 10 functional assessments reviewed (100%) were evaluated to be comprehensive and clear. This was the same as the last report when 100% of the functional assessments reviewed were evaluated as acceptable. Over the next six months, it is recommended that the facility focus on increasing the percentage of individuals with full psychological assessments. Additionally, it is recommended that MSSLC increase the percentage of current functional assessments for individuals with a PBSP.	
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 consistently 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 48 of the 161 (30%) were not conducted in the last five years. This was similar to the last report when 31% 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.	This item was rated as being in noncompliance 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, 248 of the 295 individuals at MSSLC had been at the facility at least one year and, therefore, should have an annual update. Current annual	Noncompliance

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		psychological assessments were completed for 145 of these 248 individuals (58%). This represented an improvement from the last review when 50% 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. One hundred and fifteen annual assessments were completed since the last review, and 10 (9%) 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 23 individuals were admitted to the facility in the last six months and all (100%) had an initial psychological assessment within 30 days of admission. The only barrier to achieving compliance with this provision item is that less than 90% of the individuals at the facility have a current annual psychological update. Over the next six months, it is recommended that MSSLC increase the percentage of individuals with a current annual assessment.	
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 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
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	Although there were dramatic improvements in this provision item since the last review, it was rated as being in noncompliance because documentation was not available indicating that PBSPs were consistently implemented within 14 days of receiving necessary consents and approval. A list of individuals with PBSPs indicated that 250 individuals at MSSLC had PBSPs. A list of all PBSPs and the date of last revision indicated that 249 of these (99%) were current (i.e., revised in the last 12 months). This was similar to the last review when 98% 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, 75% of the PBSPs were implemented within 14 days of receiving necessary approvals and consents. This was an	Noncompliance

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	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.	increase from the last report when 53% of PBSPs were implemented within 14 days of receiving consents. MSSLC should ensure that all PBSPs are implemented within 14 days of receiving necessary approvals and consents. One hundred and sixty PBSPs were completed in the last six months and 16 (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. All 16 of PBSPs reviewed (100%) 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 80% of the PBSPs reviewed were judged to be consistent with the stated function. Replacement behaviors are often an effective component of a PBSP because they provide a desirable alternative behavior for individuals to access the reinforcers hypothesized to maintain the target behaviors. Replacement behaviors were included in all 16 (100%) PBSPs reviewed. This was identical to the last review when 100% of all PBSPs contained replacement behaviors. 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 all of the 16 PBSPs reviewed (100%). This represented another improvement from the last report, when 80% of all replacement behaviors that could be functional were functional. Replacement behaviors were incorporated in each individual's PBSP in 15 of the 16 (94%) PBSPs reviewed. Individual #293's PBSP, however, had a replacement behavior (i.e., communicates his desire to have his gloves and take a bath) that appeared to be functional because the function of Individual #293's self-injurious behavior was related to his desire to put on or take off his gloves or take a bath. His PBSP, however, did not clearly direct DSPs to utilize this potentially effective replacement behavior, but instead included a replacement behavior, remains calm, that did not appear to be functional and, therefore, likely less effective. All PBSPs should ensure that functional replacements are incorporated in the PBSP. 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	

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		currently in the individual's behavioral repertoire (as appeared to be the case in the majority of PBSPs reviewed), the replacement behavior does not need to be written in the skill acquisition plan (SAP) format. Overall, 15 (Individual #293 the exception) of the 16 PBSPs reviewed (94%) represented examples of comprehensive plans that contained all of the following items. This was a dramatic improvement from the last review when 67% of the PBSPs reviewed were judged to be acceptable. • rationale/purpose of the plan • operational definitions of target behaviors • operational definitions of functional replacement behavior • behavioral objectives for one or more target behaviors • behavioral objectives for one or more replacement behaviors • use (or stated why not) SAPs to address the acquisition of replacement/alternative behaviors • baseline data for one or more target behavior • antecedent-based or preventative strategies • strategies to promote replacement or alternative behavior • consequence-based strategies (what to do when behavior occurred) • the use of positive reinforcement • descriptions of data collection procedures • signed and dated MSSLC should be commended for the improvements in the quality of PBSPs. In order to achieve substantial compliance with this provision item, the facility now needs to document that at least 85% of PBSPs are consistently implemented within 14 days of receiving consent.	
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,	There were improvements in this provision item, however, more work (discussed below) is required before it can be rated as being in substantial compliance. Since the last review, MSSLC expanded the collection of IOA from two to four units (see K 4). It is now recommended that the facility expand the collection of IOA to the entire facility. Additionally, it is recommended that MSSLC ensure that goal frequency and level of IOA collection 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.	Noncompliance

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	psychiatric treatment, and use and impact of psychotropic medications.	This represented another area where the facility had improved since the last review. MSSLC recently expanded the collection of PBSP treatment integrity to four units (i.e., Longhorn, Shamrock, Barnett, and Whiterock). Additionally, the facility established that treatment integrity would be collected at least quarterly for all individuals with a PBSP, and the level would be at least 80%. Available treatment integrity data provided the monitoring team indicated that, at the time of the onsite review, it averaged 48% across the four units. No treatment integrity frequency data were available at the time of the onsite review. It is now recommended that the facility expand treatment integrity across the entire facility. Additionally, it is recommended that MSSLC ensure that goal frequencies (i.e., how often it is collected) 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 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 16 PBSPs written in the last six months and concluded that they all 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 3.3 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 7.6 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	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	Noncompliance

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	competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	trainings were scheduled twice a week, resulting in many DSPs being 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 #385'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 #385's PBSP. The monitoring team found the training to be thorough. The facility maintained inservice logs on all staff training conducted by the behavioral health staff. Recently the Behavioral Services department began to systematically train float staff assigned to individuals with PBSPs. At the time of the onsite review, however, the majority of float staff were inserviced by the residential staff. Additionally, the behavioral services department did not know the method residential staff 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 295 individuals and employed 14 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 had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have at least 10 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, October 2014 – April 2014 o Medical Review Committee Meeting Minutes, October 2014 – March 2014 o Infection Control Minutes, 10/21/13, 12/9/13, 1/27/14, 4/28/14 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 21 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 #612, Individual #117, Individual #511, Individual #154, Individual #297, Individual #533, Individual #540, Individual #92, Individual #568, Individual #901 o Annual Medical Assessments the following individuals: • Individual #324, Individual #592, Individual #614, Individual #39, Individual #76, Individual #237, Individual #460, Individual #242, Individual #707, Individual #852, Individual #550, Individual #381, Individual #284, Individual #452, Individual #612 o Neurology Notes for the following individuals: • Individual #376, Individual #466, Individual #619, Individual #76, Individual #856, Individual #535, Individual #320, Individual #941, Individual #779, Individual #551 <u>Interviews and Meetings Held</u>: o Christopher Ellis, MD, Medical Director o James Gilley MD, Primary Care Physician o Admerle Hoskins-Hall, 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 Ricarda Price-Burke, RPh, Staff Pharmacist o Abigail Okeke, PharmD, Clinical Pharmacist o Thana Dhanaphibul, PharmD, Staff Pharmacist o Norris Buchmeyer, Chief Nurse Executive o Karen Wilson RN, QA Nurse <u>Observations Conducted</u>: o Daily Clinical Services Meetings o Medical Review Committee Meeting o Pharmacy and Therapeutics Committee Meeting o Medication Variance Reduction Committee Meeting o Polypharmacy Oversight 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 for this review was expanded considerably. For each of the four provision items, the self-assessment listed a number of metrics similar to those reviewed by the monitoring team. Data were provided for several of the metrics, but there were no data for a number of areas that needed to be

	monitored. It was good to see, that in moving forward, the medical director had determined what needed to be measured. Future self-assessments should be revised based on the comments and recommendations of this report. The facility rated itself in noncompliance with all four provisions items. The monitoring team concurred with the facility's self-ratings.
	Summary of Monitor's Assessment: Progress was seen in a number of areas of medical care. Staffing for the department had stabilized with no changes since the last compliance review. Preventive care continued to improve with the number of individuals who completed cancer screenings increasing. This was important because completion of these screenings allowed for early detection of disease that had the potential to have untoward outcomes. The provision of immunizations also improved. For a particular immunization, the database usually documented the number of immunizations received, the antibody status, or refusal. Annual Medical Assessments were completed in a timely manner, but they continued to need work. Quarterly Medical Summaries were inconsistently found in the records reviewed. For the record sample reviewed, documentation of care improved. MSSLC has, over a number of years, demonstrated progress. This has occurred in an environment where primary care staffing was not always stable, but was anchored by the physician who currently serves as medical director. Stability in medical staffing will be critical in achieving continued progress. The facility has much work to do, as there were a number of areas where gaps in care remained. At times, it appeared that these gaps were the remnants of the previous staffing fluctuations. Consults and labs were sometimes overlooked for a period of months. There were other issues, such as the PCP participation in the ISP process, that will require a change in both culture and systems. The PCPs must understand that attendance, while not required by regulatory standards, is vital to integration. Facility administration should further review this issue and determine how to improve ISP attendance for a medical staff with very reasonable caseloads. Other issues within the medical department also need significant attention. Health care organizations can no longer afford to not develop medical quality programs, and the health care services division of MSSLC is no different. The medical director will not know if the efforts of the department are succeeding if they are not measured appropriately. Adequate corrective action and performance improvement cannot be implemented without measurement and analysis. Fundamental to the framework of a medical quality program is the development of a robust set of policies and procedures that guide health care services. Because health care practices are to some extent fluid, policy and guideline review and revision is important. MSSLC will need to address all of these issues to move towards substantial compliance.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the above documents reviewed list. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in subsections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Staffing** The primary care medical staff was comprised of a full time medical director, two locum tenens physicians, and three full time physician employees. There were no staffing changes since the last compliance review. The average caseload was 60 with the largest being 85. The median caseload was 52. The medical director reported that he did not have a caseload. However, record reviews indicated that he was providing direct care to several individuals and completing quarterly assessments. The medical compliance nurse began working in February 2014. **Physician Participation In Team Process** <u>Daily Clinical Meeting</u> 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. <u>Medical Review Committee</u> The Medical Review Committee meeting was conducted weekly. This meeting included discussions related to ADRs, pneumonia reviews, and other topics. As noted in previous reports, the documentation of the discussions was often limited. The meeting produced a summary and not meeting minutes. The summary listed topics that would be discussed and this appeared to be the agenda for the meeting. The lack of documentation of the outcome of the discussions was problematic for several reasons. This was a committee meeting where decisions were made and those decisions must be accurately documented. Throughout the conduct of this review, the MRC meeting was often cited as the designated forum for discussion of clinical issues. However, a lack of documentation of the discussions resulted in a lack of documentary evidence that the discussions did in fact occur as reported. Finally, as a facility committee, the MRC should follow a standard meeting minute format, which should include a summary of the discussion, actions that need to occur, persons responsible for the actions, and the	Noncompliance

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		timelines. This report will highlight a number of issues related to medical care and it would appear that this meeting would be the forum to address many of the issues impacting medical care that may have occurred, but there was no documentation to support that the discussions occurred. ISP Attendance The medical department maintained data on physician attendance at ISP meetings. Those data are summarized in the table below.	

PCP ISP Attendance 2013 - 2014		
	Number of ISPs	Meetings Attended
Dec	31	2
Jan	36	1
Feb	35	1
Mar	25	2
Apr	28	4
May	28	13
Total	183	23

Based on these data, the medical staff continued to have poor participation in the ISPs. The PCPs attended 12.5% of the ISPs conducted. This was a slight increase from the 9.4% reported during the last compliance review, but remained unacceptable. The medical director indicated that this was largely due to scheduling problems. It was noted that for the month of May 2014, the medical staff attended 13 ISPs. Two of the PCPs attended 12 of the meetings. The PCP with the caseload of 85 attended 10 of 13 (77%) ISPs. The medical director was the participant for one meeting.

The medical director should encourage all PCPs to participate in the ISPs. With proper scheduling, the current caseloads of the medical staff should permit better participation in the ISP process. 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. PCPs participated in ISPs conducted during the week of the compliance review and the contributions to those meetings were important.

Risk Process
The monitoring team attended a meeting related to the facility's risk process. There were representatives from every relevant clinical discipline with the exception of the medical department. It was clear from that discussion that greater input from the primary care providers was needed in the discussion of medical risks. Risk assessment is discussed further in the documentation of care.

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		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. 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: • 10 of 10 (1000%) AMAs were completed in a timely manner • 7 of 10 (70%) AMAs included comments on family history • 10 of 10 (100%) AMAs included information about smoking and/or substance abuse history • 10 of 10 (100%) AMAs included information regarding the potential to transition	

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		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: • 14 of 15 (93%) AMAs were completed in a timely manner. • 11 of 15 (73%) AMAs included comments on family history • 14 of 15 (93%) AMAs included information about smoking and/or substance abuse history • 14 of 15 (93%) AMAs included information regarding the potential to transition The medical staff completed AMAs using the state issued template. The record sample included assessments done in a variety of old formats as well as a few done in the new format. All of the AMAs included in the facility submitted sample were completed with the new template. The quality of the AMAs was particularly provider specific. Some assessments were thorough and detailed. Individuals with complex medical problems tended to have more thorough assessments. One provider was even including the MOSES and DISCUS evaluation information as part of the medication side effect monitoring and it was good to see that this information was being thoughtfully utilized. Unfortunately, some providers consistently failed to include required information in the assessments of the individuals. These individuals often had significant psychiatric issues and received multiple medications that required monitoring. The following are some of the concerns noted in the sample of AMAs reviewed: • Individuals were documented to have a history of smoking, but there was no evidence that counseling was provided or a smoking cessation program was offered. • The preventive care was cited as "routine" or "up to date." • The immunization section did not include any data. • There was no laboratory or x-ray information documented. • Lab values were sometimes listed as "borderline" instead of stating the actual values. • Plans were often stated as "continue protocol." Some assessments indicated that the weight or HbA1c of the individual was abnormal. In most of those cases, it was an individual who received a new generation antipsychotic medication, but the PCP did not discuss the other risks for metabolic syndrome. In fact, none of the assessments reviewed included any assessment of risk. Identification of risk, mitigation of risk, and implementation of plans is an essential component of primary care and should be included as part of the Annual Medical Assessment. The monitoring team has recommended in the past and continues to recommend identification, in the Annual Medical Assessment by the that primary medical providers, medical risk factors, methods to mitigate risk when possible, and plans to support the	

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		individuals above and beyond risk mitigation. Overall, there was a considerable amount of work that needed to occur with the completion of the AMAs. The medical director should continue to work with the medical staff to ensure that the AMAs include the required components. <u>Quarterly Medical Summaries</u> The medical department utilized the state issued template for completion of Quarterly Medical Summaries. For the records contained in the record sample: • 8 of 10 (80%) records included a QMS for the most recent two quarters. Compliance with this requirement was increasing and the content of the summaries was improving. The summaries were not always completed by the PCP documented as the attending physician and discrepancies in data were observed. <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. Even so, the APLs reviewed sometimes did not include all active diagnoses. <u>Integrated Progress Notes</u> For the record sample reviewed, providers documented in the IPN in SOAP format when the entry involved a clinical encounter. The notes were usually signed and dated. Post-hospital documentation improved. The post hospital template was usually completed following hospitalization. One to two follow-up notes were generally seen in addition to the initial post-hospital note. There was also improvement in the documentation of follow-up of acute conditions. The medical staff consistently initialed diagnostics, such as labs and x-rays and consultation recommendations. There were IPN entries related to the diagnostic studies. <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. Physician orders were observed that were not consistent with recommended doses. In those cases, the doses were double the FDA recommended doses. Incomplete orders were noted with indications and stop dates being most	

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		problematic. This is discussed in section N1. Consultation Referrals The facility tracked consultations with a local database. A new IPN template was implemented in February 2014. A total of 40 consults completed after October 2013 was reviewed: • 33 of 40 (83%) consultations were summarized by the medical providers in the IPN within five working days. Moreover, starting in March 2014, the IPN notes included a summary statement regarding the reason for the consult and significance of the findings, agreement, or disagreement with the recommendations, and the need for IDT referral. This system appeared to be effective in relaying information regarding consultations to the IDTs. 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. Overall, compliance with the completion of cancer screenings was quite good. Preventive care services, such as cancer screenings and osteoporosis screenings, were tracked in databases. Data from the 10 record reviews listed above and the facility's preventive care reports (databases) are summarized below: Preventive Care Flow Sheets For the records contained in the record sample: • 10 of 10 (100%) records included PCFSs • 7 of 10 (70%) forms were signed, dated, and current The Preventive Care Flow sheets were found in all of the records reviewed. Many of the PCFSs needed updating or completion. Dates of immunizations were not provided and some information that was available was not recorded. There was improvement in the physician signing of the forms. As noted in the last compliance review, 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 writing various diagnostic	

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		results in the margins. The forms should be signed and dated in the spaces provided when updated. Immunizations • 9 of 10 (90%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations or had documentation of status • 9 of 10 (90%) individuals had documentation of varicella status Overall, per the facility immunization database, 5% of individuals did not have documentation of varicella status. Moreover, a few individuals were noted to be immune based on date of birth. The CDC does indicate that individuals born before 1980 can be considered immune to varicella. However, it is incorrect to apply this standard in a long-term care facility. Specific recommendations are made for health care professionals, residents, and staff in nursing homes and residential settings. The varicella vaccination is recommended for those individuals. The monitoring team discussed the use of the federally required Vaccine Information Statements with the medical director who reported that this was the responsibility of the RN case managers. The immunization records found in the active records included a section to record VIS information. While the VIS may have been provided to the individuals and the LAR, the active records included no documentation in the immunization records, IPNs, or physician orders regarding the provision of the Vaccine Information Statements (VIS). State policy indicated that informed consent was to be obtained for all immunizations. However, medical policy did not explicitly state the requirement for provision of the VIS or the documentation of the VIS. The National Childhood Vaccine Injury Act requires that all health care providers in the US, who administer to any child or adult certain vaccinations, such as, but not limited to, varicella, tetanus, influenza, and hepatitis B, provide prior to administration of each dose, a copy of the "relevant current edition VIS produced by the CDC." Health care providers are also required by this federal law to "make a notation in each patient's permanent medical record at the time vaccine information materials are provided" the version of the VIS and the date provided. This is a requirement in addition to noting the vaccine manufacturer and name of the person administering the vaccine. Screenings • 10 of 10 (100%) individuals received appropriate vision screening • 8 of 10 (80%) individuals received appropriate hearing testing Prostate Cancer Screening • 2 of 5 males met criteria for PSA testing	

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		• 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: • 44 of 47 (94%) males had current PSA results documented • 3 of 47 (6%) males did not have current results due to refusal or new admission status <u>Breast Cancer Screening</u> • 5 of 5 females met criteria for breast cancer screening • 5 of 5 (100%) female had current breast cancer screenings o 1 of 5 females had incomplete studies due to lack of cooperation A list of females age 40 and older was provided. The list included the names of 41 females, the date of the last mammogram, and explanations for any lack of testing: • 33 of 41 (80%) females had current breast cancer screenings • 4 of 41 (9.7%) females did not have current screenings due to age • 4 of 41 (9.7%) females did not have current screenings due to refusal or other reasons <u>Cervical Cancer Screening</u> • 5 of 5 females met criteria for cervical cancer screening • 5 of 5 (100%) females had gyn evaluations completed o 3 of 5 (60%) females completed cervical cancer screening within three years A list of females age 21 and older was provided. The list included the names of 43 females, the date of the last pap smear, and explanations for lack of testing: • 31 of 43 (72%) females completed cervical cancer screening in 3 years • 10 of 43 (23%) females did not complete due to age >65 • 2 of 43 (4.6%) females did not complete for other reasons <u>Colorectal Cancer Screening</u> • 7 of 10 individuals met criteria for colorectal cancer screening • 6 of 7 (85%) individuals completed colonoscopies for colorectal cancer screening o 1 of 6 (16%) individuals had an incomplete colonoscopy due to technical issues o 1 of 7 (14%) individuals refused testing	

#	Provision	Assessment of Status	Compliance
		A list of individuals age 50 and older was provided. The list contained 80 individuals: • 68 of 80 (85%) individuals had completed colonoscopies • 4 of 80 (5%) individuals had not completed colonoscopies due to refusal • 2 of 80 (2.5%) individuals had not completed colonoscopies due to refusal by GI provider • 6 of 80 (7.5%) individuals had not completed colonoscopies due to other reasons **Disease Management** The facility implemented numerous clinical guidelines based on state issued clinical protocols. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. Data derived from record audits and the facility reports are summarized below. <u>Pneumonia</u> There were 22 incidents of pneumonia between November 2013 and April 2014. The total number of incidents reported is listed in the table below. The medical staff was provided pneumonia protocol cards, which were updated following the March 2014 external reviews. The cards served as reminders for the primary care providers to address issues, such as head of bed elevation, the need for habilitation, SLP, nutrition, GI and pulmonary consults, the need for completion of swallow studies and other diagnostics, and the review of aspiration risk factors inclusive of medications that increased risk. The medical director believed the protocol cards were helpful in reminding staff about the various clinical protocols that were implemented. Pneumonia cases were reviewed during the Medical Review Committee. A checklist was implemented in April 2014. The checklist was completed for each individual reviewed. Clinical disciplines, including SLP, OT/PT, nursing, pharmacy, dental, nutrition, and medical each completed a review of the relevant issues. Decisions were made regarding the most appropriate diagnosis based on the information available and recommendations were made. Beginning in April 2014, meeting notes documented follow-up on the recommendations such as diagnostic and consult results. Prior to February 2014, discussion in the MRC did not occur consistently based on the meeting summaries submitted. The monitoring team reviewed all summaries from November 2013 – April 2014 and found documentation of pneumonia tracking and discussion for the following dates: 11/13/14, 2/12/14, 3/26/14, and 4/9/14.	

	Oct	Nov	Dec	Jan	Feb	Mar	Apr
No. of Incidents	6	5	7	0	2	3	5

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		The review of the facility's aggregate pneumonia data was documented in the Infection Control Committee meeting minutes. Discussions were noted relative to trends and potential solutions. For example, there was some concern about compliance with the requirement for individuals who received enteral nutrition to remain upright. Recommendations were made related to increased mealtime monitoring and this was good to see, but a specific plan and follow-up on that recommendation was not documented. It appeared that MSSLC had systems in place to (1) provide the medical staff with appropriate information related to pneumonia management, (2) to review pneumonia cases with a standardized checklist, and (3) to conduct a facility level review of pneumonia data through the Infection Control Committee. Some of the processes were relatively new and there was a need to improve documentation of follow-up on some recommendations, and ensure that individuals with recurrent events were aggressively managed. Overall, the facility was moving in the right direction with regards to pneumonia management. <u>Diabetes mellitus</u> The facility achieved compliance scores greater than 80% on both the external and internal medical audits. However, there was evidence that the identification of individuals with metabolic syndrome was problematic. Individuals with metabolic syndrome and those with HbA1c in the "pre-diabetic" range should be clearly identified and aggressively managed because they are at increased risk for the development of overt diabetes mellitus. **Case Examples** Individual #612 • This individual presented to GI for a screening colonoscopy in 2012 at the age of 61. Testing revealed a large fungating colon mass that was locally invasive. The individual required a hemicolectomy, which was considered curative at the time of diagnosis. This case underscores the importance of timely colorectal cancer screening. This individual had the initial screening colonoscopy 11 years later than recommended. Individual #901 • This very young individual had an abnormal EKG in 2013 and, therefore, had a stress echocardiogram that showed moderately reduced left ventricular function and severe concentric hypertrophy suggestive of an infiltrative process. A follow-up cardiology evaluation was done in 2013 and the cardiologist recommended treatment with low dose beta blockers. It was	

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		recommended that the individual return for further invasive interventions if symptoms developed. The recommendation of the cardiologist to start beta-blockers was not implemented until 5/22/14. The reason for the seven-month delay was not clear. Individual #533 • This individual had numerous medical problems including hypertension and seizure disorder. The individual appeared to have several criteria for metabolic syndrome, including hypertension treated with medication, an abdominal girth of 50 cm, and an HDL of 29. The glucose levels were usually elevated with a value of 119 recently documented. The PCP noted that the individual probably had acanthosis nigrans and would be monitored for development of diabetes due to the association of acanthosis nigrans and endocrine disorders. However, there was no association with or discussion of metabolic syndrome. • This individual also had a TSH of 6 in January 2014. IPN documentation in January 2014 and the QMS indicated that the endocrine consult from 1/23/14 was pending. The IPN note dated 2/14/14 documented discussion of the endocrine consult, but did not address the elevated TSH. The records did not include any follow-up of the TSH. Individual #154 • This individual's first screening colonoscopy occurred at the age of 62 years in May 2014. A polyp was removed which was identified as a tubular adenoma. These adenomas have the potential to become malignant, therefore, this procedure may have prevented development of a future malignancy. • The individual was seen by gynecology in July 2013. Completion of the pelvic exam was difficult. The gynecologist indicated that the risk for cervical cancer was low because previous pap smears were negative and the individual was not sexually active. It was further stated that an argument could be made for not doing further pelvic exams unless the individual had problems. It was noted that the consultant was not provided the family history. The cause of death for the individual's mother was ovarian cancer. The individual's sister was also diagnosed with ovarian cancer. While this information may not affect the need for cervical cancer screening, a <u>strong family history</u> of ovarian cancer definitely impacts the decision to continue to have pelvic examinations. It also must be considered when deciding if additional screening for ovarian cancer is warranted. Further gynecological examinations were deferred based on the comments of the gynecologist, however, the consultant was not provided the appropriate family history (risk factors) and even noted in the consultation that no history was available.	

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		Seizure Management Similar to the December 2013 review, the medical department submitted inaccurate seizure management data. Approximately 88 individuals were diagnosed with seizure disorder. AED polypharmacy data were submitted for 216 individuals. The monitoring team indicated in the last monitoring report that for the purpose of seizure management, AED polypharmacy data should be limited to the use of AEDs for seizure management. It is important for the medical department to track and monitor key seizure data inclusive of the use of older, more toxic, drugs and AED polypharmacy. This requires the use of accurate data. 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- 2014		
	On-Campus	Off-Campus
Nov	10	7
Dec	11	8
Jan	12	17
Feb	6	8
Mar	11	9
Apr	17	8
Total	67	57

The on-campus clinic was conducted one and a half days each month. Individuals were seen in the neurology clinic and in the neurology-psychiatry clinic. The overall number of appointments appeared adequate. There was an average of 20 appointments each month.

Documentation of seizure management for 10 individuals over the past 12 months was requested. Data from those records are summarized below:

- 3 of 10 (30%) individuals were seen at least twice over the past 12 months
- 5 of 10 (50%) individuals had documentation of the seizure description
- 7 of 10 (70%) individuals had documentation of current medications for seizures and dosages
- 6 of 10 (60%) individuals had documentation of recent blood levels of antiepileptic medications
- 3 of 10 (30%) individuals had documentation of the presence or absence of side effects
- 0 of 10 (0%) individual had documentation of information included on the

#	Provision	Assessment of Status	Compliance
		MOSES/DISCUS evaluations • 9 of 10 (90%) individuals had documentation of recommendations for medications • 0 of 10 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc. The notes submitted were for appointments completed at the campus clinic. The consultation form was one page that consisted of five boxes. Nearly one quarter of the form was used for demographic data. The other sections were labeled reason for consult, Dx, Rx, and plan. This format was not appropriate for documentation of a thorough neurology consultation. Individuals having an initial consultation did not have medical history, medications, allergies, drug trials, or any of the historical information that should be included as part of any complete evaluation. Follow-up consultations documented drug levels, but never mentioned the laboratory values associated with drug use. Attention was never given to the side effects of medications even when individuals were on multiple AEDs. The rationale for AED selection was not clear. For example, the choice of older and more toxic AEDs should include a clear rationale for use. Moreover, the medical department should be tracking the use of such medications. The monitoring team observed the neurology-psychiatry clinic for Individual #154. The neurologist completed an examination of the individual. Following this evaluation, the neurologist met with the IDT for further discussion. The individual was an active participant in the process. There was no procedure to guide how this clinic was conducted or to define what the outcome of the clinic would be. During the clinic, the QIDP had discussions with the individual that were not necessary relevant to the reason for the clinic evaluation. There was no meaningful discussion with the neurologist and when he attempted to speak, he was interrupted. The monitoring team did not observe any presentation by the neurologist of his findings or any discussion of the medication regimen, drug interactions, or medication side effects. There should be a format for conducting neurology-psychiatry clinics. The use of a template would ensure that the necessary issues are reviewed. **Access To Specialists** The medical director reported that the state database was not used. The facility had access to Scott and White's data system and consults could now be directly retrieved. The active records included missed appointment forms that were reviewed by the PCPs, but there were no data on the turn around time for completion of appointments. It was reported that the problems observed during the last review were resolved, but the monitoring team saw some examples of consults that appeared to be delayed or, for other reasons, simply did not have timely follow-up. The medical director must ensure that systems are in place to ensure that (1) consults are prioritized and completed within	

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		the appropriate timeframes, (2) failed appointments are rescheduled when appropriate, and (3) consults are received in a timely manner. **Do Not Resuscitate** 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 four names (Individual #432, Individual #120, Individual #185, Individual #43). The reasons for the DNRs were listed as hospice, guardian request (2), and multiple co-morbidities. Individual #432 had a DNR executed in 2011 while receiving hospice services at another facility. The DNR was signed by two physicians involved in the hospice care of the individual at that time. There did not appear to be any involvement of the LAR. Hospice care was terminated in 2012. There was no additional information regarding the need for this continued DNR other than the MSSLC medical director stating the DNR was appropriate. The DNR was continued based on the 2011 document. There was no review by the Ethics Committee even though there was no LAR involved in the decision to continue the DNR. The monitoring team has recommended in previous reviews and continues to recommend that the facility review the list of individuals with DNRs and for every individual ensure that the long term DNRs are clinically justified and fulfill all requirements of state policy. The monitoring team recommends that facility management and state office review this process. Specifically, the DNR for the individuals with no LAR should have review by the facility's Ethics Committee. <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 medical director should review the specific clinical issues noted in this section. The medical director should address other issues noted within the body of this report.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></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>Medical Reviews - External
An external medical reviewer conducted Round 9 of the medical audits 3/6/14 - 3/7/14. 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 18 records that were reviewed as part of the general medical audits. Those data are summarized in the table below:

<table><tr><th colspan="3">General Medical Audits
Compliance (%)</th></tr><tr><td></td><td>Essential</td><td>Non-essential</td></tr><tr><td>Round 9</td><td>94.2</td><td>96.6</td></tr></table>
The target score of 80% was not achieved for Question #31 which addressed inclusion of indications for medication orders. In addition to the general medical audits, medical management audits were also completed. Three records were reviewed for each of the selected medical conditions. The results for the medical management audits are listed below.

<table><tr><th colspan="4">Medical Management Audits
Compliance (%)</th></tr><tr><td></td><td>Diabetes mellitus</td><td>Osteoporosis</td><td>Pneumonia</td></tr><tr><td>Round 9</td><td>82</td><td>100</td><td>70</td></tr></table>
The 70% compliance for pneumonia was due to questions related to the PCP addressing the review of risk, interventions for individuals at risk, and the providers' review of medications to determine risk assessment. The medical director addressed these issues by revising the pneumonia clinical indicator cards to include further explanations in these areas. Corrective action plans continued to be developed by the QA department. Data indicated that all corrective action plans were completed.

The facility completed the external review within the required timeframe and implemented corrective actions for identified deficiencies. The review did not detect any issues with the AMAs, which were significant. This may have been due to the sample size.

This review uses only one source of information to assess medical care, the active record. The sample size will need to be sufficient to make a reasonable determination with regards to the quality of care provided. Twenty-seven records were reviewed with nine of the records having a focus on only one specific medical issue. General medical</td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>care was assessed for 18 individuals. The sample size for review of general medical care may not be sufficient and should be increased to reflect the requirement for 10% sample.

<u>Mortality Management at MSSLC</u>
There were two deaths in 2013. The average age at the time of death was 59.5 years. There were three deaths since the last compliance review. The mortality documents for the three deaths that occurred in 2014 were reviewed. Information for those deaths is summarized below:
• The average age of death was 49 years with an age range of 35 to 51 years.
• The causes of death were:
o Lung cancer with metastasis
o Acute decompensation hypercapnic ventilatory failure, chronic hypercapnic respiratory failure
o Aspiration pneumonia, anoxic brain injury, cardiac arrest
o No autopsies were performed.

The monitoring team met with the medical director, CNE, QA nurses, and facility director to discuss mortality management at the facility. 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)
• Ensuring that all hospital information is obtained for review
• Having external reviews completed by qualified physicians, such as <u>board certified primary care physicians</u>, 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 facility should address the issues discussed above.</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;</td><td><u>Internal Medical Reviews</u>
The internal medical audits were completed 3/10/14 – 3/12/14 using the same sample from the external audits. The results are presented in the table below.

<table>
<tr><th colspan="3">General Medical Audits
Compliance (%)</th></tr>
<tr><td></td><td>Essential</td><td>Non-essential</td></tr>
<tr><td>Round 9</td><td>97</td><td>98.4</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	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.	

Medical Management Audits Compliance (%)			
	Diabetes mellitus	Osteoporosis	Pneumonia
Round 9	100	100	100

The findings of the pneumonia internal audits were significantly different from that of the external audits. Given that there was a 30-percentage point difference, it is imperative to examine the inter-rater reliability. Generally, when raters do not agree, the tools are defective or the raters' use of the tools is problematic. The facility had not addressed inter-rater reliability at the time of the compliance review.

Medical Quality Program

The facility had not developed a formal medical quality program. Quality programs require a number of structures including a QI Committee, calendar, clinical practice guidelines, policies and procedures, peer review process, chart audits, tracking systems and data sources. In addition to the internal/external medical audits, MSSLC had some systems in place including:

- Medical director chart audits - The medical director initiated chart audits in April 2014 in which he reviewed the AMAs to determine the quality of the assessments. An assessment tool was developed for this purpose. Feedback was provided to the PCPs. The tool included information similar to that seen in the external audits. The tool should be expanded to include an assessment of the management of disease conditions not covered by the medical audits.
- Data on preventive care was being tracked, but the medical director needs to look at preventive care data aggregately and not monthly. There should also be better documentation of the studies, which have been deferred and discontinued.

There were a number of ongoing activities that should have been part of the process of assessing medical quality, but the facility had not developed a set of quality metrics. Thus, many aspects of medical care that should have been monitored were not. For example, there were no key metrics to determine the quality of neurological care provided. Similarly, there was information available related to physician prescribing patterns, but there was no defined metric that could be used to make determinations about the quality of care. The monitoring team noticed possible trends from a sample of clinical intervention forms. Hospital data were maintained, but the medical department did not review the number and types of hospitalizations as part of the MRC. Individuals

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		with multiple hospitalizations did not undergo any particular type of further review and there was no comprehensive assessment of the care provided to individuals with a diagnosis of diabetes mellitus. MSSLC should identify metrics (process, outcome, and structural) to be measured and develop a medical quality committee. This must be a specific committee with time allocated to meet and review data. As a formal committee, the medical director should serve as the chairperson and minutes should be taken and forwarded to the facility director and QA department. Quality is an integral part of an organizations culture. The facility will not know the adequacy of the care provided if it is not properly measured. 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 director should review the inter-rater reliability associated with the medical audits. 2. The facility must proceed with developing a comprehensive medical quality program as discussed above.	
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 33 local medical policies (MSSLC Medical Policies #1 - #33). These policies addressed the provision of medical, psychiatric, pharmacy, and dental care. Clinical issues, guidelines, as well as departmental and facility operations were covered in these policies and procedures. Local versions of state medical policies were included in this series of documents, however, the monitoring team noted that the local versions of policies were adopted without making any facility specific modifications. Therefore, the facility's medical care policy, which provided the framework for the provision of care, lacked a description of the basic medical staff requirements and job duties, such as caseload responsibilities, completion of clinical rounds, on-call coverage responsibility, and weekend coverage. It was also noted that many policies were not updated in a number of years, with several having no updates in nine to 10 years. During the December 2013 compliance review the medical director conducted "pretraining" for the diabetes mellitus clinical care guidelines during the MRC meeting stating there would be further discussion of the protocol. MRC summaries did not document any further discussion of the diabetes protocol, however, the physicians had	Noncompliance

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		received a number of clinical protocol cards. Training records were submitted providing evidence that the medical staff were informed of various policies and procedures as they were implemented. It was not clear that the medical staff had been fully trained on all of the state issued clinical protocols. There remains an outstanding need for the medical department to have a comprehensive medical manual that includes the relevant information related to operations of the department and provision of health care services. This would include, but not be limited to information on staffing and caseloads, the role of the PCP in the IDT process, requirements for participation in ISPs and ISPAs, and participation of primary providers in various meetings. Procedures related to delivery systems should be provided, such as how consults are ordered, the process for obtaining labs, ordering x-rays, and the various tracking systems. The department must also have a system in place for reviewing all policies and procedures on a regular basis and updating as necessary. This is typically done on an annual basis. <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 department needs a comprehensive medical department manual consisting of policies and procedures related to medical care <u>and</u> the overall operations of the department. 2. The facility should continue to develop guidelines for other common medical conditions based upon the needs of the facility. 3. Each member of the medical staff should have a medical department policy and 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 <u>reviewed on a yearly basis and updated as necessary</u>.	

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>: ○ MSSLC Section M Self-Assessment, updated: 5/9/14 ○ MSSLC Section M Action Plan, updated: 5/5/14 ○ MSSLC Section Presentation Book ○ Active Record Order and Guidelines ○ Map of facility ○ MSSLC Nursing Services Organizational Chart, including titles and names of staff currently holding management positions ○ 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 ○ MSSLC New Employee Orientation agenda ○ MSSLC QA/QI Council Meeting Quality Assurance Reports ○ MSSLC Clinical Monitoring Meeting Minutes, 6/2/14, 6/3/14 and 6/5/14 ○ MSSLC Analysis of Hospitalizations/ER Visits/Frequent Moves on Campus, 12/1/13 - 4/23/14 ○ SSLC Nursing Policy: Nursing Services #010.3, effective 6/17/13 ○ SSLC Nursing Guidelines/Protocols/Procedures • Comprehensive Nursing/Quarterly Nursing Record Review/Quarterly Physical Assessment, revised: 1/14 • Care Plan Development, revised: 12/13 • Seizure Management Guidelines, revised: 12/13 ○ SSLC Nursing Protocols: • Enteral Medication Administration, revised: 12/13 • Enteral Nutrition, revised: 12/13 • DIASTAT AcuDial, revised: 12/13 • Blood Glucose Monitoring, revised: 12/13 • Pretreatment and Post-Sedation Monitoring, revised: 12/13 ○ SSLC Nursing Procedures: • Nurse Competency Based Training Curriculum: revised 12/13 • Management of Acute Illness and Injury, revised: 12/13 • Management of the Foley or Supra-pubic Catheter, revised: 12/13 • Neurological Assessment, revised: 12/13 • Medication Administration Observation Guidelines, revised: 12/13 • Medication Administration Guidelines, revised: 1/14 • Self-Administration of Medication Skills Assessment, revised: 12/13 • Gastrostomy Tube: Insertion by a Nurse, revised: 12/13 • Enteral Nutrition, revised: 1/14

	○ SSLC/MSSLC Blank Nursing Forms • Enteral Feeding Record, revised: 4/14 • Medication Observation Form, revised: 11/12/13 • Self-Administration of Medication Monthly Data/Progress Note, revised: 12/13 • Diabetic Record POR-MR-20 (8/2002) • Insulin injections (anterior view), MSSLC-NS-13 • Treatment Record MSSLC-NS-28 ○ MSSLC Administration of Oxygen, revised: February 2014 ○ MSSLC Home and Life Training Manual Revisions • Oral Hygiene Care and Suction Toothbrushing, 12/31/13 • Nurse Competency Based Training Curriculum Guidelines, March 2014 ○ MSSLC Home Life & Training Manual Nursing Services Competency/Check Off– NS 55, 1/9/14 • Care and Use of Enteral Feeding Devices • Compat Dual Flow Enteral Delivery System • Direct Care Staff Instructions for Handling Enteral Feeding Devices • Do's and Don'ts of Enteral Feeding Documentation ○ MSSLC 2014 Annual Competency Based Training/Skills Packet • MSSLC Guidelines for Care and Use of Enteral Feeding Devices/ Enteral Feeding Record MSSLC-NS-45, 1/9/14 ○ MSSLC Preceptorship training curriculum ○ MSSLC Line listing by RN, LVN, Nursing Competency/Skills Testing ○ MSSLC Listing AED and Emergency Bag Locations ○ MSSLC AED and Emergency Equipment Check List: 5/1/13- 6/2/14 ○ MSSCL Last six months Equipment Walkthrough ○ MSSLC last six months Summary and Analysis Review of AED and Emergency Equipment Checklists ○ MSSLC Listing of CPR/First Aid Certifications Delinquency List, run date 5/8/14 ○ MSSLC last six months, all code blue/emergency drill reports, including recommendations and/or corrective action plan ○ MSSLC last six months, nursing audits, data analysis, reports, sample size, staff completing the audits and plans of correction ○ MSSLC listing of Mealtime and Snack Integrated Progress Notes (IPNs) and Meal Time Observations conducted Face-to-Face monitoring by RN Case Managers ○ MSSLC Alphabetical list of individuals with current ISP, annual nursing assessment, and quarterly nursing assessment (due) dates ○ MSSLC Alphabetic list of individuals with Gastrostomy, Jejunostomy, G/J tube, tracheostomy, colostomy, ileostomy, Foley catheter, and Port-A-Cath by residence ○ MSSLC Eternal Tube Changes Tracking Document ○ MSSLC list of individuals ever diagnosed with human immunodeficiency virus ○ 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 SSLC Most Integrated Setting Practices, #018.2, 11/18/13 o MSSLC Last five community discharges and hospitalizations o MSSLC Immunization Tracking report, June 2014 • Immunizations Procedures, dated 10/1/08 • Vaccine Immunization Record for Adults, NS-80 (Adults) dated, 1/07 • Vaccine Immunization Record for Children and Teens NS-81(Children and Teens) dated, 1/07 • Immunizations Requirements for Children and Students (April 1999) • Hepatitis B Vaccination Declination o MSSLC Vaccine Dispensing Log o MSSLC Guidelines for Acquiring, Administering and Documentation of Individual's Immunizations (Vaccines) – revised 4/7/14 • 2014 Advisory Committee on Immunization Practices (ACIP) Recommended Adult Immunization Schedule and persons aged 0 through 18 years o Texas Vaccine For Children Program (TVAC): Provider Enrollment, dated 1/8/01 o Current listing of Physicians administering TVFC supplied vaccine K-8 Exhibit E o Texas Department of Health (TDOH) Monthly Vaccine Inventory o TDOH Temperature Recording Form o TDOH Eligibility Screening Record/Eligibility and Vaccine Doses Administered Report o Vaccine Adverse Event Reporting System Report o SSLC Preventive Health Care Guidelines, 8/30/11 o MSSLC last six months infection control trending reports o MSSLC Infection Control Committee Meeting and associated documents, 6/2/14 o MSSLC Skin Integrity Meeting Agenda and associated documents, 6/2/14 o MSSLC last six months of, minutes from the following meetings: Infection Control, Skin Integrity, Specialty Nurses Meeting, Nurse Manager Meeting, Weekly Nursing Focus Meeting; and Medication Error Committee Meeting o MSSLC last six months Antibiograms o MSSLC Last six months Enteral Nutrition/G-J Tubes meetings and associated data o MSSLC Enteral Feeding/G/J Tube Cap Review Meeting, dated 3/24/14 and associated data o SSLC Medication Variance Policy #053, effective: 9/23/11 o MSSLC Medication Variance Review Committee (MERC) Agenda for October Data, 6/22/14 o MSSLC last six months of, 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 Unit Glucometer Log Sheet, May 2014 o MSSLC list of individuals at risk of aspiration, cardiac, challenging behavior, choking, constipation,

	dehydration, diabetes, GI concerns, hypothermia, infections, injury, medical concerns, osteoporosis, polypharmacy, respiratory, seizures, skin integrity, urinary tract infections, and weight o MSSLC last six months of minutes for 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 #518, Individual #533, Individual #120, Individual #451, Individual #361, Individual #293, Individual #360, Individual #444, Individual #117, Individual #188, Individual #150, Individual #591, Individual #297, Individual #549, Individual #779, Individual #415, Individual #610, Individual #875, Individual #932, Individual #628, Individual #988, Individual #702, Individual #745, Individual #972, Individual #885, Individual #992, Individual #844, Individual #863, Individual #973, Individual #812, Individual #639, Individual #716, Individual #197, Individual #479, Individual #192, Individual #557, Individual #119, Individual #285, Individual #101, Individual #659, Individual #466, Individual #284, Individual #233, Individual #195, Individual #395, Individual #309, Individual #100, Individual #373, Individual #569, Individual #502, Individual #568, Individual #730, Individual #761, Individual #619, Individual #170, Individual #220, Individual #790, Individual #554, Individual #892, Individual #377, Individual #432, Individual #185, Individual #432, Individual #38, Individual #65, Individual #54, Individual #57 <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 RN Case Managers, Robyn Sterling, RN, BSN and Sherry Bonner RN o Immunization Nurse, Nancy Fortenbury, LVN o Infection Control Preventionist, Phillip Morton, RN, BSN o Hospital Liaison, Rosemary Roberts, RN, BSN o Nurse Educator, Genia Duke, RN o Nurse Managers o Quality Assurance Nurses, Karen Wilson and RN, Dawn Price, RN o Campus RN, Direct Care RNs, LVNs, RN Case Managers, and Direct Support Professionals (DSP's) o Immunizations/Immunity meeting - 6/3/14 o Enteral Tubes/Devices meeting - 6/4/14 <u>Observations Conducted</u>: o Medication Administration Observation (various units) o Enteral Administration of Medications (various units) o Residential areas at various time of the day

	○ Emergency Equipment (various units) ○ MSSLC Clinical Services Morning Meeting - 6/2/14, 6/3/14, and 6/5/14 ○ Infection Control Committee meeting - 6/2/14 ○ Skin Integrity Committee meeting - 6/2/14 ○ Nursing Administration Meeting - 6/3/14 ○ ISP meeting – 6/3/14 ○ Unit Daily Morning Meeting - 6/4/14 (Martin) ○ ISPA meeting – 6/4/14 ○ Mortality meeting – 6/4/14 ○ Medication Variances Review meeting by Nursing/Pharmacy/Medical - 6/5/14 ○ At Risk meeting – 6/5/14 ○ MERC meeting - 6/5/14
	Facility Self-Assessment The facility submitted a self-assessment for section M. For each provision of M, the facility identified activities engaged to conduct the self-assessment, results of the self-assessment, and a rationale for the self-rating. The facility's self-assessment included 12 months of data for the majority of its audits. The self-assessment included the number of audits conducted, analysis of the audits, and provided explanations for any trends upward or downward. The audits conducted were a mixture of both retrospective and real time. The self-assessment did not include inter-rater reliability audits. Each provision included specific actions that were completed or in process. The majority of action steps contained items that were measurable for completing the facility's action steps. In addition, the facility presented data in other areas, e.g., counseling/corrective actions. The self-assessments were in alignment with the monitoring team's report. The facility rated itself as being in substantial compliance with section M1, M2, M4 and M6. The monitoring team agreed with the facility's self-ratings for M2, M4, and M6.
	Summary of Monitor's Assessment: The CNE and NOO assured there were ongoing measurable performance objectives for nursing in adhering to policies/ procedures/protocols, and lack of adherence/failures were addressed with the appropriate remediation. The RN Compliance nurse conducted ongoing state approved audits. She was observed many times on the units providing constructive re-education and mentoring to nurses, as part of the real-time audit process.

	The Hospital Liaison had been instrumental in assisting the facility in gaining remote access to real-time hospital records. The Hospital Liaison continued to make daily visits/contact, attend ISPA meetings, and track movement of individuals within the facility. The facility continued to refine its practices of ensuring that new nurses, when hired, were sufficiently trained, including classroom and bedside competencies, and that each was assigned a preceptor. New RN Case Managers caseloads for adding individuals was a gradual process and based on levels of competencies obtained by the RN Case Manager. The nursing assessments for reporting and responding to individuals with acute illness or injury were consistent in addressing/documenting their health care needs, timely notification to practitioners, and followed established nursing protocols. The facility had re-vamped the collection of its Immunity/Immunization data because the AVATAR system was inadequate to provide/track the necessary data. The facility developed detailed spreadsheets that documented each individual's immunity/immunization data. The spreadsheets produced data that provided an ongoing status of the individual's immunity/immunization data. Staff were observed in many areas by the monitoring team, at different times of the early morning, day, and evening. Standard precautions were observed being adhered to and hand hygiene techniques were followed. In addition, they prompted or assisted individuals with their hand hygiene, and provided prompts how germs are spread, such as in the avoidance of sharing beverages between individuals. To maintain substantial compliance for M2, the nursing department must continue to improve upon their summary statements, to include substantive statements that qualify the status of each of the individual's risks, response to interventions, and demonstrate whether or not the individual is progressing or regressing toward his/her IHCP goals. The facility should also add an additional step of conducting inter-rater reliability when conducting the Annual Comprehensive Assessment tool. The RN Case Manger Supervisor implemented a process to ensure RN Case Managers were addressing the gap of time occurring between the completion of the admission/annual nursing assessment and the actual date of the ISP for developing the IRRF/IHCP. This included developing plans of care, staff instructions, and including any changes in health status in an addendum to the nursing assessment. The facility had implemented a process for a multidisciplinary review of all medication errors by Nursing, Medical, and Pharmacy, as recommended by the monitoring team. The facility continued to maintain its robust systems of collecting and analyzing medication variances, addressing medication variances, and where risks are identified, producing solutions to reduce or minimize harm.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The monitoring team conducted its own independent review of the facility's self-assessment, action plans, raw and analyzed data/audits, and information presented in section M. The monitoring team held interviews and meetings with the CNE, NOO, RN Compliance Nurse, RN Case Manager Supervisor, RN Case Manager, Immunization Nurse, Hospital Liaison, Infection Control Preventionist, Nurse Educator, QA Nurses, direct care RNs, LVNs, and DSPs. The monitoring team also reviewed individual records, conducted nursing interviews, observed on units/clinic, and attended a variety of meetings. <u>Staffing, Structure, and Supervision</u> The facility's census was 295. At the time of this visit, there were 75 RNs and 47 LVNs. The number of nursing vacancies for LVNs for October 2013 through March 2014 ranged from 16 to 20 per month. At the time of this visit, the facility reported 21 LVN vacancies. The facility used agency nurses to staff, though 50% of the agency nurses had worked at MSSLC for two years or longer. There were no RN vacancies at the time of the review. The Nursing Department's monthly analysis of minimum nursing staffing patterns documented the occurrence of 11 shifts that fell below the established minimum staffing for November 2013 through April 2014. The CNE had a system in place for: • Tracking all call ins, no shows, and procedures for taking appropriate action • Monitoring set minimum staffing patterns • Ongoing recruitment and retention activities • Monitoring overtime, and the rationale for the overtime Since December 2013,the Nursing Department had: • Maintained consistent leadership staff (CNE, NOO, Compliance Nurse) and specialty nurses (Hospital Liaison, Nurse Educator, Infection Preventionist) • Although the nursing department had set minimum standards, the CNE should enlist the assistance from the state nursing coordinator to assist with the development of a system that takes into consideration the acuity of the individual's health needs and risks. During the review, the monitoring team made observations of 24 individuals in their homes or day program area across the five units during the early morning, mid-day, and evening. The monitoring team observed 47 nurses (direct care RNs, RN Case Managers, Nurse Managers, LVNs,) on the units/clinic area. The nurses were observed performing assessments, providing enteral nutrition, changing dressings, and administering medications. • An example of one of these observations was for Individual #628. The individual had an assigned personal sign language interpreter present that was used when communicating between him and staff. The monitoring team also used this assistance to communicate to the individual. He used sign language to proudly tell about the fishing activity he had recently engaged in, and the fish he had caught. The individual was receiving his enteral	Noncompliance

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		nutrition in a manner that was acceptable to him, while watching his preferred shows on TV. The enteral feeding was administered in accordance with prescribed orders and followed infection control standards for monitoring and dating the enteral feeding devices. <u>Availability of Pertinent Medical Records</u> For the records reviewed in this report: • All of the nursing-related documents requested were provided • The Subjective, Objective, Assessment, and Plan (SOAP) format was consistently followed when documenting in the IPNs • Several records contained late entries, which were appropriately noted as such • The majority of the nurses' signatures and titles were legible • The Nurse's entries were consistently timed. • Records consistently documented 24 hour chart checks were completed. • In the record for Individual #185, the 24 hour chart check, associated documents for the acute change in status the IPN notes, neurological record, and applicable physician orders were located in the chart. <u>Hospitalization and Hospital Liaison Activities</u> During the interview with the Hospital Liaison, it was positive to learn that the facility had obtained remote access to real time records for one of the major hospitals. The Hospital Liaison provided a copy of the database where she tracked movement of individuals within the facility, and had just begin to trend for any associated health issues with the transfers of the individuals. The monitoring team will follow-up the status at the next visit. The Hospital Liaison reported she performed the following activities: • Completed Hospital Liaison Reports • Distributed Hospital Liaison Reports to the appropriate disciplines • Attended ISPAs for all hospitalizations • Maintained Hospital/ER Spreadsheets • Conducted Audits • Attended Daily Provider Meetings, and reported on the status of hospitalized individuals • Made hospital rounds or phone contacts, Monday through Friday. The facility had an assigned nurse for weekends and holidays for follow-up on individuals who were hospitalized • Requested and distributed information from hospitals • Maintained Individual Movement Spreadsheets • Communicated and collaborated with Infection Control, PNMP Nurse, Physicians, and RN Case Managers • Provided culture reports to the Infection Preventionist	

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		Based on a review of five individuals that were hospitalized: Individual #533 (vomiting with G-tube, fever), Individual #188 (vomiting/J-tube out), Individual #593 (UTI), Individual #518 (feeding tube dysfunction), and Individual #779 (seizures with fall and head injury): • Five of five (100%) IPNs included documentation of a focused nursing assessments prior to the hospitalization based on the relevant protocol. • Five of five (100%) records included documentation that the nursing staff notified a physician, and obtained transfer orders that included the mode by which the individual should be transported. • Five of five (100%) contained documentation of the transfer form, and was sent to the receiving ER/Hospital. • Five of five (100%) Hospital Liaison reports were sufficiently completed. • Five of five (100%) Hospital Liaison reports were found in chronological order within the IPN notes. • Five of five (100%) records showed daily visit/contact to the hospital for which there was evidence of collaboration between the Hospital Liaison and hospital staff/facility staff. • Five of five (100%) ER/LTAC assessments were completed within two hours of the return to the facility. • Five of five (100%) ER/LTAC assessments included as applicable instructions (e.g., Individual #188 record regarding the individual stoma site). • Five of five (100%) records documented the attendance of the Hospital Liaison at the ISPA. For each of the individuals, the Hospital Liaison documented relevant information and suggestions/recommendations related to the hospital stay. • Five of five (100%) records contained an ACP and staff instructions. <u>Infection Control Education/Inservice Training</u> • Pre-service classes • Trichomoniasis, focused unit training • Vaccine Distribution, vaccine administration • Intradermal PPD injections, and reading of PPDs • Standard Precautions/Hand Hygiene for new admissions • Transmission base precautions for new employees Evidence of ongoing teaching for hand hygiene was found in the majority of the records reviewed, as part of their ongoing assessments. Individual #65 was a positive example. The Infection Preventionist, during the Daily Clinical Meeting, was observed in providing a report about status of individuals' infections. The report included any positive culture reports, individuals who required isolation, and a short summary of the treatment for the infection. The monitoring team visited one of these individuals, Individual #730, who had a soft tissue	

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		infection, and was in Contact Isolation, which was used to prevent transmission from an infected or colonized patient through direct touching of the patient) or indirect touching of surfaces or objects in the patient's environment. The monitoring team and DSP followed the contact isolation instructions posted on the door prior to entering and after exiting. The individual was observed watching TV. His affected leg was elevated and had secure dressing. The individual was verbal. He was aware that he had an infection and appeared to understand the need for the protection from the spread of germs. He quickly pointed out where the trash can and red bag can were in the room for disposing of the contact isolation personal protective equipment. Hand Sanitizer was available both inside and outside the room for completing hand hygiene. The monitoring team observed the DSP completing her hand hygiene correctly before and after. The monitoring team also reviewed his individual notebook and found the ISP, IHCP, ACP, and staff instructions present. The monitoring team also asked questions regarding the staff instructions to which the DSP responded correctly. <u>Infection Preventionist Activities</u> • Developed a detailed spreadsheet for the tracking individual's immunity/immunization status and providing an analysis of individuals for their current immunity/vaccination status, after an attempt to run a report from AVATAR showed a problem with data analysis • Conducted Infection Control Rounds with Safety and Life Safety Officer • Communicates and collaborates with DSPs, Nurses, Physicians, Hospital Liaison, Pharmacy, and Housekeeping • Chairs the Infection Control Meeting • Produced in collaboration with Pharmacy/Medical Antibiograms • Supervision and monitoring of the Vaccine Administration Program • Collects/analyzes data • Conducted Hand Hygiene Monitoring The facility reported, for the period of January 2014 through April 2014, 100% compliance with hand hygiene. The monitoring team attended the Infection Control Meeting that was chaired by the Infection Preventionist. During the meeting, data were brought forth from Infection Control Rounds. The team raised the following issues during the meeting for continued planning and intervening to address: • Findings and Actions taken in response to the Infection Control Rounds The above item was pending further review of the committee. The monitoring team will follow-up at the next visit.	

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		The facility infection data were reported quarterly. Cellulitis (soft skin infection) comprised the highest number of infections overall for October 2013 through December 2013 and for January 2014 through March 2014, followed by UTI for the same time periods. The report contained an analysis of the data. The report did not include specific prevention strategies in reducing the number of infections. The facility also had an increase of pneumonias from none in January 2014 to six in April 2014. The facility should have more discussions regarding their infection rates and prevention strategies for reducing those infection rates. <u>Immunizations/Immunity Status of Individuals</u> The monitoring team held a meeting with the Infection Preventionist, NOO, and Immunization Nurse to review their recently developed spreadsheet, after noting that several individuals were due or past due immunizations according to the vaccine schedule. The IP immediately began reviewing the datasheet to follow-up on the vaccine orders and their consents. The facility provided an analysis of the number of individuals vaccinated or had immunity. The data were questionable when comparing the numbers and percentage to the facility's census. More work is needed here. It was positive that the facility had taken the initiative when its own systems for capturing immunization data did not produce for the facility acceptable reliable reports. The monitoring team selected a number of records for review. The information requested included the individual's consent, immunization record, any titers, physician orders, and the Vaccination Information Sheet Publication for the vaccine administered. The sample was Individual #580, Individual #992, Individual #610, Individual #932, Individual #875, Individual #972, Individual #54, Individual #844, Individual #973, Individual #855, Individual #863, Individual #812, Individual #360, Individual #549, and Individual #885. • 14 of 14 (100%) records contained a consent form • 14 of 14 (100%) records contained a VIS Publication (but see section L) • 14 of 14 (100%) records had physician orders for their vaccine or titers The immunization records were problematic for: • Individual #992's physician order, dated 5/15/14, to obtain consent and begin Hep A/B series. The vaccine order remained to be carried out. • Immunization Records were not accurately completed in accordance with the facility own policy regarding documentation of Vaccine Information Statement (VIS). Much education is needed regarding the VIS and the associated required state/federal regulations with vaccinations. Also see section L of this report. The monitoring team also visited two units where vaccines were maintained. Each were found to have the required Vaccine Storage Contingency Plan, and electronic refrigerator and freezer temperature thermometers. Each unit had a checklist for daily review of thermometers. None	

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		were found with blanks, and temperatures were within the recommended parameters. The vaccines, in both places, were found in date, and dated when opened. The monitoring team reviewed, onsite, Individual #339's Immunization record, IPN note, and physician order for which the individual received four vaccinations. The IPN note documented the vaccine, the site the vaccine was administered in, and a plan for follow-up to monitor the vaccine site and any changes for signs and symptoms or adverse reactions for the vaccines. The vaccine was documented on the Immunization record. The facility reported, as of 4/29/14, based on census of 307. • 98% Individuals received their flu vaccinations, for the remaining percentage, there was an explanation (e.g., allergic to vaccine) • 51% of the staff had received a flu vaccination, for the remaining number, there was an explanation (e.g., 11.4% declinations, for various reasons) • 100% of individuals were compliant with their annual TB Skin testing • 100% of employees were compliant with their annual TB Skin testing <u>Wound and Skin Integrity</u> The monitoring team attended the Wound and Skin Integrity meeting where there was much discussion on how the data were represented or not represented. For example, distinguishing between individuals who had hospital or community acquired pressure areas. Although the meeting contained many disciplines, it did not appear that the prevention strategies were fully integrated. For example, nursing had identified areas of needed improvement in care (e.g., positioning, re-positioning). However, there was no discussion during the meeting as to what strategies should be put in place to assure integration in prevention of skin integrity issues or for maintaining skin integrity. The scant data appeared to rely heavily upon those individuals who experienced, or were identified as having, a skin breakdown, rather than having a system in place for maintaining skin integrity. It was noted that a number of individuals had skin breakdown occurring at the hospital. It is imperative that the both facilities, sending and receiving, have common goals (e.g., the individual's risk, adequate use of admission and discharge information). During the week, the CNE provided the monitoring team with updated information as to the number of individuals with a pressure area, for which there was one who had a Stage 2. It appeared the set of data presented in the Wound and Skin Integrity meeting was a work in progress. The monitoring team will follow-up at the next visit as to the status of the pressure areas and skin integrity issues. <u>Emergency Response</u> • Based on the monitoring team's observations of the emergency equipment, for five of the units reviewed, (100%) of the AED/Emergency Equipment was located, and each had	

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		signage for locating the Emergency Equipment/AED. • For each of these sites, (100%) nursing staff proficiently demonstrated that the oxygen, AED, and suction machine were (100%) were functionally operating, and the batteries were charged. • 100% of the Emergency bags were present, clean, stored properly, and secured with a numbered pull lock • Nurses were quizzed on how the equipment would be operable during an event of loss of power. All of the nurses' responses were consistent, in that both the suction machine and AED had a battery as the backup. In addition, the nurses' responses included their knowledge of location of the color-coded power outlets, connected to the facility's emergency power (generator). • An onsite review for the AED and Emergency, Emergency Bag, Emergency Oxygen Tank and Suction Machine checklist for these areas for June 2014, were (100%) completed as required by facility policy. • The monitoring team also reviewed all of the May 2014 checklists for all areas with emergency equipment for which there were 17. Sixteen of 17 (94%) were found complete. One contained a blank for one day, for which the NOO had documented the nurse received performance counseling. The facility documented from 10/1/13 to 3/31/14, an overall compliance of 99% for its checklists/logs. • The facility also conducted unannounced inspections of the emergency equipment, by a member of the safety committee. The monitoring team reviewed the 3/24/14 data submitted by the facility, and found that all 17 areas had inspections completed. None of 17 required corrective actions. Also, the facility submitted evidence of these re-occurring inspections for January 2014 through May 2014 across five different units, all of which did not require any corrective action. • The facility submitted its "run delinquency report" dated 5/8/14, and the applicable certifications were (100%) current for CPR (Basic CPR or BLS). • The facility had an extensive spreadsheet for tracking code blue drills in place. The spreadsheet and included a summation of the total number of drills conducted, and a percentage of pass and fail. The spreadsheet included detailed information for the date of each drill and review in IMRT for any corrective action/critiques that were done in real time (on the spot). The data showed the actual and attempted number of drills conducted. The overall percentage pass rate was for 97% for drills conducted November 2013 through April 2014. For the percentage of failures, the facility submitted detailed information as to actions taken, including performance counseling. • The facility had a formal Medical Emergency Response Committee. The submission of for November 2013 through April 2014 minutes contained discussion of CPR drills, presentation of items tracked and trended, emergency equipment, and any additional equipment needs or replacement needs.	

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		Assessment and Documentation Changes of Individuals with Acute Changes in Status Based on a review of five individuals for seven acute changes in health status that occurred in the last three months (April, May, and June 2014). Individual #65's head injuries and skin integrity issue, Individual #451's head injury, Individual #628's, asthma, Individual #255's urinary tract infection, and Individual #424's skin integrity issue: • Seven of seven (100%) nursing IPNs contained baseline information for the individuals' illness/injury • Seven of seven (100%) nursing IPNs had an initial assessment that included a full set of vital signs and SAO2 • Seven of seven (100%) of the assessments dictated by the symptoms were in alignment with nursing protocols. • Seven of seven (100%) of the records contained documentation of frequent assessments for the individual's health issues that were in alignment with the nursing protocols. • Seven of seven (100%) were written consistently in the SOAP documentation format. • Seven of seven (100%) had timely notification to his or her physician for the illness or injury. • Seven of seven (100%) nursing IPNs assessed and documented each individual's pain, following the nursing pain protocol. • Seven of seven (100%) of the health problems were followed through to resolution in alignment with nursing protocols. • Three of three (100%) for head injury, the nursing protocol was followed. • Two of two (100%) for the fall or suspected fall, the nursing protocols were followed. • One of one (100%) respiratory protocol was followed. • One of one (100%) urinary tract infection protocol was followed. • Two of two (100%) antibiotic protocols were followed. • Seven of seven (100%) of the records requiring an ACP for the identified acute change in status health problem were found in the record. See M3 for ACP review. • The monitoring team, during a visit on one of the units, observed Individual #185 become unsteady. Nurses and DSP quickly came to her aid and conducted necessary assessments, including vital signs and oxygen saturation, following standard precautions when supporting her wound needs. Later, the monitoring team returned to review the record onsite, and found the fall, head injury, and pain protocol had been appropriately implemented. There was documentation the nurse had reviewed the unified record for history of falls. The nurse was also in the process of developing an ACP. It was also positive to observe the caring approach displayed by the DSP and members of the nursing team. The facility held Clinical Morning meetings for review of the last 24 hours of care, consults, individuals with acute care changes, etc. The monitoring team attended several of these meetings. The meeting was chaired by the medical director. The meeting was attended by a variety of	

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		disciplines. The meeting included a review : • 24 hour Nursing Report • On-Call physicians/psychology • Hospital Liaison Report • Infection Control Report • Recommendations and follow-up to those recommendations • Consultations • Crisis Intervention/Restraints • Admissions/Placements/CLDP/Transfers For each item, there was a short summation of the issue/status for each individual listed on the 24 hour nursing log. As previously recommended by the monitoring team, and as observed, the Infection Preventionist report presented during the meeting was now included in the body of the Clinical Morning Report document. <u>Nursing/QA Quality Enhancement Efforts</u> The Nursing Department continued to re-asses its own findings from nursing audits. Nursing leadership looked beyond their scores to ask questions about what they wanted to achieve with the audits, how we they know, and what changes can they make that will result in improvement. One example included asking the DSP instructions written by the nurse to observe or perform a function, such as to carry out droplet precautions. For this audit, the nurse reviewer had determined that clear instruction was needed as to what droplet precautions mean and how to carry them out. In addition, the Compliance Nurse documented actions taken to rectify the issue. The facility continued its quality assurance process in the oversight monitoring of enteral feedings, problems associated with the G, G/J devices, and problems with associated nursing documentation, for which the facility had minutes and graphs. The monitoring team met with the RN Case Manager and LVN who tracked information placed on the graphs. During the discussion, the monitoring team suggested the facility also consider cross-referencing the existing data by individual as to the frequency of occurrences. Nursing was in agreement that this was important to track. QA Nurses interviewed commented on the continued positive relation with nursing and their presence at a variety of meetings held by nursing (e.g., Enteral Nutrition/G/J Tube, MERC, Mortality, Infection Control). The monitoring team observed the QA Nurses in several meetings where they provided positive statements and suggested system changes or re-evaluation of existing systems (e.g., Infection Control Meeting). There was also documentation found in the Enteral Nutrition/G/J Tube meeting notes on 5/20/14, attended by QA, that included individual records reviewed by QA, their findings, and follow-up report of actions taken by nursing to address the issue.	

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		The QA Nurses also completed mortality summaries and tracked all mortality recommendations to resolution. The Nursing Morality Recommendation Tracking log showed the nursing department had nine recommendations with a required timeline completion in 30 days from the stated date of 5/27/14. The monitoring team will follow-up at the next visit as to the status of the recommendations. See section L for more information on mortality. The facility's provision M1 Self-Assessment self-rated substantial compliance with this provision, but the monitoring team was not in agreement. There was evidence that the facility continued to make progress toward achieving compliance in all of the various requirements contained in this provision. 1. The CNE should enlist the assistance from the state office nursing coordinator in the development of staffing plans that include an acuity component. 2. The facility should work toward an integrated system approach that sufficiently qualify strategies for maintaining skin integrity. 3. The facility should ensure the conducted 24 hour chart checks are providing the information/checks for which they are intended for, to assure drift is not occurring, for example, regarding physician orders. 4. The facility should assure that there are clear definitions for the reportable skin integrity issues. 5. Ensure that Infection Control Reports are thoroughly discussed in the Infection Control meeting, and that recommendations and their action steps are tracked to resolution. 6. Ensure infection prevention is a component of the facility's quality assurance program and infection prevention reports (e.g., infection control rounds, findings, and actions taken) are made available to QA. The monitoring team also suggests developing and conducting compliance rounds that are title specific. For example, indwelling catheters, and dressing/wound care/isolation precautions (contact/droplet). 7. Ensure the Immunity/Immunization Infection Control Guidelines, Admission Policies for Immunity/Immunization histories (if there is one), and the facility Medical Policies are congruent with one another. 8. The facility should follow its own policies and procedures when completing Immunization records (e.g., MSSLC Infection Control Manual K-8).	
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	<u>RN Case Manager Responsibilities</u> • Attend and participate in ISPAs, ISPs, and CLDP meetings • Attend and participate in Unit Meetings • Complete Nursing Assessments for Admissions, Annuals/Quarterly and Community Discharges (CLDP) • Implement/Review/Revise/Resolve Plans of Care • Conduct Mealtime monitoring Audits	Substantial Compliance

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	nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	Revised Guidelines • Comprehensive Nursing/Quarterly Nursing Record Review/Quarterly Physical Assessment, revised: 1/14 Training/Education/Inservice • Physical Assessment (RN Case Managers 100%) • SOAP Documentation (RN Case Managers 100%) • Acute Care Plan (RN Case Managers 100%) • At Risk Training (RN Case Managers 100%) • Comprehensive Nursing/Quarterly Nursing Assessment, format, and associated instructional prompts (RN Case Managers 100%) • NEO and Nursing Orientation (RN Case Managers 100%) • Classroom and bedside Competencies (RN Case Managers 100%) During an interview, the RN Case Manager Supervisor described her implementation of proactive steps to assure there were not gaps in care. An example was addressing the time between the Admission Nursing Assessment and the occurrence of the 30-day ISP meeting. The RN Case Managers were instructed to complete addendums between the dates of the admission nursing assessment and the actual date of the ISP. This additional step was to assure the individuals assessment addressed the most current behavioral and health problems. In addition, the RN Case Manager Supervisor developed a plan of care, with staff instructions, for the individual's admission diagnosis. The monitoring team's review of Individual #745 and Individual #628's records found evidence of these addendums, plans of care, and staff instruction. The RN Case Manager Supervisor had established a process for ensuring the RN Case Managers reviewed, within one business day, the ER/LTAC form and checked the PST box to indicate members were notified of a change in status. Even so, more direction is needed from the state nursing coordinator for the expectations by the RN Case Manager beyond the signing, dating, and checking the PST box on the ER/LTAC form. The monitoring team reviewed three of the most recent hospitalizations ER/LTAC forms for Individual #188, Individual #518, and Individual #293 and found: • One of three (33%) ER/LTAC records contained the RN Case Manager Signature, date, and that the PST box was checked. • Two of three (67%) ER/LTAC records were reviewed by the RN Case Manager within one business day. Individual #518's record was not dated. The monitoring team also attended an ISPA for Individual #297 and observed the RN Case Manager providing current information as to her health status after undergoing a procedure	

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		requiring sedation. Members of the IDT and the individual were present. The RN Case Manager provided an update of the individual's surgery report and planned follow-up care by the individual's surgeon. The team had discussions regarding her health, safety, and risk for falls or potential injuries due to the recent surgery and agreed upon a level of supervision with timelines for reviewing. It was positive to observe the multidisciplinary approach taken by the team. The monitoring team reviewed the record and found that the RN Case Manager had documented the ISPA in the nursing IPN. The monitoring team also attended a unit meeting on one of the homes, and the RN Case Manager was in attendance. She was participatory. She readily contributed information about individuals on her caseload. The monitoring team reviewed a sample of 18 Admission/Annual/Quarterly Nursing Assessments with dates between 1/6/14 and 6/3/14. The sample included individuals with medium and high risk from each of the homes, completed by 11 RN Case Managers. These were reviewed using a monitoring tool comparable to the tool used by the MSSLC facility, which included the revised Guidelines: Comprehensive Nursing Assessments Quarterly Nursing Record Review Quarterly Physical Assessment. The 18 individuals were Individual #297, Individual #885, Individual #988, Individual #745, Individual #702, Individual #628, Individual #451, Individual #591, Individual #761, Individual #619, Individual #188, Individual #65, Individual #415, Individual #57, Individual #293, Individual #255, Individual #170, and Individual #220 • 18 of 18 (100%) of the assessments contained the required components of the assessment, the record review, and physical assessment. • Five of five (100%) Admission Comprehensive Nursing Assessments were completed in accordance with the guideline. • One of one (100%) Admission (readmission) was for an individual hospitalized over 30 days in accordance with the guidelines. • Five of six (83.33%) Annual Comprehensive Assessments were completed 10 working days prior to the date of the ISP meeting. Individual #188 was completed three days prior to the ISP. • Six of six (100%) Quarterly Nursing Record Reviews/Physical Assessment were completed by the last day of the month in which the quarterly assessment was due. • The facility data showed that the overall percentage for timeliness for Annual/Quarterly Comprehensive assessments for April 2013 through March 2014 was 90%. The monitoring team's overall percentage was 92%. • 11 of 12 (92%) Admission/Annual Nursing Assessments Section I. History for the applicable area were complete and contained sufficient summarization of the history section. Individual #188 was a negative example. Individual #988 was a positive example. • 11 of 12 (92%) individual's functional status were adequately addressed.	

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		• Four of four (100%) assessments with a positive history for infections contained adequate information regarding the infections. • Eleven of 12 (92%) provided an immunization/immunity status, including that the immunization was up to date and/or provided a summary as to the status of titers or need for vaccinations. Individual #702's immunization/immunity status was not addressed. • 12 of 12 (100%) documented the PPD was completed and provided the results. • 11 of 12 (92%) included medical diagnoses that corresponded to the individual's active problem list. • Six of six (100%) annual assessments documented the current medium or high risks from the last annual or change in status. (The remaining five new admissions contained documentation to be determined at the ISP held within 30 days of admission.) • 11 of 12 (92%) of the assessments sufficiently addressed the effectiveness of the individual's medication. In one example, Individual #451 received Ibuprofen for 10 days for his back pain, but the effectiveness was not addressed. • 11 of 12 (92%) sufficiently addressed the individual's End of Life Planning. • 12 of 12 (100%) contained documentation of mealtime monitoring by a nurse, and the results of the monitoring. Nine of the monitoring were completed within the month of the ISP being held. • Three of five (60%) new admissions contained a sufficient nutritional evaluation. Individual #988's assessment was a positive example of sufficiently addressing the nutritional evaluation. • 11 of 12 (92%) assessments documented the preferences, strengths, and goals in accordance with the guidelines. Even so, few of the preferences, strengths, and goals noted on the assessment form, as copied from the pre-ISP, contained statements that sufficiently incorporated health. • 18 of 18 (100%) admission/annual/quarterly assessments contained opinions or statements by the nurse for addressing most integrated living options. Even so, the opinions varied from nurse to nurse, indicating training was needed for nurses to have an understanding of supports that are available in the community. • 18 of 18 (100%) admission/annual/quarterly records contained documented MOSES/DISCUS (for which a MOSES and/or DISCUS was required) results, including the date of completion and score. Individual #170 was a positive example. • 16 of 18 (88%) of the records sufficiently addressed the individual's SAM program that included the status of the evaluation, ongoing program toward progress, or lack of progress. Individual #188 was a positive example that addressed the rationale for not participating in SAM. Individual #297 was a negative example. • Nine of 12 (75%) records sufficiently included suggested interventions or recommendations. Individual #65 was a positive example. • 8 of 12 (66%) annual/quarterly assessments were deficient in consistently and in sufficiently qualifying the status of the individual in terms of progress, stability, and status	

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		of their related objectives. • The facility's overall percentage for quality Annual/Quarterly Comprehensive Assessments for February 2013 through March 2014 was 96%. The monitoring team found an overall average score for quality was 90%. The Nursing Department should address those items that had a significantly lower score. The facility's self-assessment provided action steps taken by the facility to achieve their scores. This included a review and refinement of their RN Case Mangers hiring and orientation process, supervision for reviewing timelines and measuring quality, implementation of tracking system for assessments, performance coaching and individual performance reviews for RN Case Managers, holding regular focus meetings, and having a designated preceptor/mentor assigned. The facility conducted peer review audits, and supervisory audits were conducted for Nursing Assessments, using a tool that was in alignment with the revised nursing format/nursing guidelines. To maintain substantial compliance, the nursing department must continue to improve upon their summary statements, and include substantive statements that qualify the status of each of the individual's risks and response to interventions, and demonstrate whether or not the individual is progressing or regressing toward his/her IHCP goals. The facility should also add an additional step of conducting inter-rater reliability, when conducting the Annual Comprehensive Assessment tool.	
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.	<u>Revised Policies</u> • Care Plan Development <u>Training/Education/Inservice</u> • Understanding the Acute Nursing Care Plan (100% nurses trained) The monitoring team reviewed the ACPs for five individuals who had seven recent acute changes. (See M1, Assessment and Documentation of Individuals with Acute Changes in Status.) • Five of seven (71%) ACP plans had baseline data that sufficiently described the issue for the implementation of the health care plan • Four of seven (57%) plans contained nursing goals to sufficient to identify the outcomes from their acute illness/injury • Seven of seven (100%) plans contained the date the plan was implemented • Six of seven (86%) plans contained the date the plan was resolved • Six of seven (86%) plans contained documentation that the plan was reviewed in accordance to the ACP policy • Three of three (100%) plans that contained an applicable change in condition were revised	Noncompliance

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	Nursing interventions shall be implemented promptly after they are developed or revised.	• Seven of seven (100%) plans were implemented within the timeline in accordance with the ACP policy • Five of seven (71%) plans included sufficient preventive measures • Three of seven (43%) staff instructions contained a date implemented by the nurse. • None of the seven (0%) of the staff instructions contained a date that each staff member receiving staff instructions, due to a flaw in the state format that did not have a place marker for date. • Four of seven (57%) were individualized. <u>Community Discharge Planning/Community Discharge Summaries</u> The state office issued correspondence that discontinued the Nursing Discharge Summary format and replaced it with the Comprehensive Nursing Review format that was used for Nursing Assessments, effective 2/1/14. The Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Assessment Guidelines, dated January 2014, did not have a corresponding timeline for the completion of the CLDP. Reportedly, there were no staff instructions issued to the RN Case Manager Supervisor for the guiding and training RN Case Managers for distinguishing the purposes between using the same document for a nursing assessment and as a discharge summary for effectively guiding community staff to understand the individual's present health status, in order to respond to their mental/behavioral/health care needs, implement appropriate actions, and recognize individual risk. The facility implemented the new CLDP form. In a discussion with the RN Case Manager Supervisor, she said she was developing some prompts for the RN Case Managers to follow when utilizing the new format for the purpose of discharge planning. In addition, she had proactively provided guidance that the RN Case Managers were to include changes that may have occurred from the initial date of the CLDP to the date of discharge. The monitoring team found evidence of this for Individual #309 regarding his being treated for an infection, his response to treatment, when the problem was resolved, and an administered immunization in accordance with his vaccine schedule. Based on a review by the monitoring team of Individual #373, Individual #309, Individual #569, Individual #502, and Individual #100: • Five of five (100%) summaries were completed on new CLDP format • Five of five (100%) CLDP summaries were completed within 45 days of the planned discharge date • Four of five (80%) had each section complete. For example, Individual #100's did not address sleep history. • None of five (0%) CLDP summaries as specified, "See attached list of medications" were included with the CLDP summaries. • Two of five (40%) CLDP summaries specified how the individual liked to take medication	

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		(e.g., orally, crushed) or included what mediums or fluids were a preference. For example, Individual #100's record noted that "pills are cut to ½ inch length to prevent choking or aspiration, and that he was on altered textured diet." The record was not specific if the individual took the pills with a liquid or if they were placed in a textured medium. • None of the five (0%) CLDP summaries included individualized comprehensive interventions and staff training needs for each individual's identified mental/health problems. The facility self-rated noncompliance in revising and resolving, updating health care issues, and noted more specific monitoring was needed to quantify improvements. The monitoring team found evidence that much work had been put forth in providing education and training/inservice regarding the implementing the changes in the ACPs and that the nursing department had begun to gather data as to the effectiveness of the staff instructions as part of their audit tool. Even so, continued work is needed in the area of developing plans of care that are consistent and individualized, and written in staff instruction terms easily understood for reporting changes in the individuals mental/health problems or needed supports.	
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.	There was documented evidence of a communication process for acknowledgment of new or revised policies, procedures, protocols, and internal nursing directives. There were staff signatures and documentation that changes were incorporated as appropriate into the Nursing Training Manual. Since the last visit the facility, had a number of new and revised state policies, procedures, and form changes: • Comprehensive Nursing/Quarterly Nursing Record Review/Quarterly Physical Assessment, revised: 1/14 • Care Plan Development, revised: 12/13 • Seizure Management Guidelines, revised: 12/13 • Enteral Medication Administration, revised: 12/13 • Enteral Nutrition, revised: 12/13 • DIASTAT AcuDial, revised: 12/13 • Blood Glucose Monitoring, revised: 12/13 • Pretreatment and Post-Sedation Monitoring, revised: 12/13 • Nurse Competency Based Training Curriculum: revised 12/13 • Management of Acute Illness and Injury, revised: 12/13 • Management of the Foley or Supra-pubic Catheter, revised: 12/13 • Neurological Assessment, revised: 12/13 • Medication Administration Observation Guidelines, revised: 12/13 • Medication Administration Guidelines, revised: 1/14 • Self-Administration of Medication Skills Assessment, revised: 12/13 • Gastrostomy Tube: Insertion by a Nurse, revised: 12/13 • Enteral Nutrition, revised: 1/14	Substantial Compliance

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		• Enteral Feeding Record, revised: 11/13 • Medication Observation From, revised: 11/12/13 • Self-Administration of Medication Monthly Data/Progress Note, revised: 12/13 <u>Training/Inservice Education</u> The Nurse Educator continued to have a system for tracking each nurse's classroom and bedside competencies. This included the facility's annual skills fair testing for 2014, which showed 100% of the nurses were compliant. During the period of January 2014 through May 2014, the following classes were scheduled and taught by the Nurse Educators. • Flex Pen Training (Novalog) • Restraint • Self-Advocacy • Acute Nursing Care Plan Development (RNs100% trained) • IHCP/Risk (RN Case Manager, 100% trained) • Death Review • Staff Medication Administration • On the Job Training Nurses • Trichomoniasis (unit specific) • Seizure • Acute Nursing Care Plan Development • Medication Aide Testing • Mosby Physical Assessment • Mosby Chapters Ears, Nose Throat (RNs, 100% trained) • SOAP In addition to classes and bedside competencies, the nursing department continued to have in place a preceptor program. Twenty-two of 22 (100%) preceptors completed the annual facility required training. The monitoring team reviewed records and found that the facility continued to have sufficient formalized systems in place for tracking the completion of state and facility required trainings for all nurses, including new hires. The facility maintained an updated training manual that reflected changes made by DADs and from their local policies. The facility system included statistics to provide the percentage of nurses trained by subject matter and number of nurses remediated. The training included classroom and bedside competencies prior to the individual providing direct care. Each nurse was assigned a mentor to further provide nursing oversight and mentoring. The monitoring team reviewed Individual #150, Individual #120, Individual #117, Individual #361, and Individual #444 for compliance with the applicable Pretreatment and Post Sedation protocol for which all of the procedures were performed in the hospital or outpatient setting. For	

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		each of the procedures, there was documentation of a review of the Medical Review Committee (MRC) for the request for pretreatment sedation performed outside the facility. Even though none of the five received sedation at the facility prior to the procedure, there was evidence for five of five records that nursing applied the nursing protocol upon arrival back to the unit. • Five of Five (100%) nursing IPNs contained documentation of the type of procedure/treatment. • Four of five (80%) utilized the ER/LTAC/form for completing the initial assessment upon return to the facility. Each of the four were sufficiently completed. • Five of five (100%) contained a full set of vital signs including SPO2 • Five of five (100%) documented the vital signs in accordance with the protocol schedule. • Five of five (100%) nursing assessments included an initial assessment gait/balance/coordination, mental status, lung sounds skin color, and assessed and monitored the individuals intake, bowel and bladder status. • Five of five (100%) assess the individual for pain, using the applicable pain scale. • Five of five (100%) contained an applicable initial and resolved ACP for the procedure/treatment related to the prescribed health procedure. • Five of five (100%) contained instructions to staff specific to the procedure or potential unexpected outcomes from the procedure of signs and symptoms to report. In addition the monitoring team found: • Individual #65 was assessed by Nursing on 5/24/14 at 8:00 pm due to an abrasion. The information was documented on the facility's IPN-1 (Wound) note. The assessment for the skin integrity issue included measurements of the documented abrasion, a pain assessment, and staff instructions for monitoring specific signs and symptoms. An ACP was not required, in accordance with the facility's ACP policy. The IPN notes provided documentation of follow-up that included vital signs and a measurement of the site. The abrasion was documented as healed on 5/28/14 at 7 pm. For each IPN initial and follow-up entry follow-up entry, the SOAP documentation format was followed. Each entry included an adequate assessment, vital signs for the affected area, and followed the pain protocol. • Individual #415 was assessed by Nursing on 3/24/14 at 3:25 pm for his complaint, "I have an eye headache." A full set of vital signs was obtained, including a physical assessment of his head, eyes, lungs, and abdomen. Nursing intervention included administering a prescribed analgesic for the pain. The record documented instructions to the individual and to the staff. On 3/24/14 at 4:25 pm, the Nursing IPN documented follow-up on the individual's headache and response to his pain medication. The IPN nursing assessment included full vital signs, and physical assessment of his head, eyes, lungs, and abdomen. The individual reported, "I feel better." An ACP was not required, in accordance with the facility's ACP policy. The nursing pain protocol was followed. • Individual #988 was diagnosed with an ear infection upon admission. Medicated ear	

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		drops and an antibiotic were ordered by the individual's PCP. Nursing interventions included administering the medications, implementation of an ACP, and instructions to the individual and staff for signs and symptoms to report. The pain protocol and antibiotic therapy protocols were implemented and followed to resolution. The IPN documented the ear infection was resolved on 3/18/14 at 9:00 am. The ACP was also documented as resolved on 3/18/14. The facility's overall average for all protocols February 2013 through April 14 was 90%. The monitoring found care was consistent with the protocols for pain, antibiotic therapy, skin integrity, and post sedation. The facility maintained substantial compliance. The facility should continue its positive efforts in conducting real time audits, and produce shoulder to shoulder mentoring to assure the implementation of policies, procedures, and protocols.	
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 monitoring team attended the section I meeting. The RN Case Manager Supervisor provided an overview of inservice training conducted for all RN Case Managers on the IRRF. She also had refined the IRRF by adding additional prompts. The additional prompts were reported as being shared with other team members. The meeting also included a discussion regarding how assessments were tracked. Each department tracked their own assessments. For example, Nursing tracks all Annual/Quarterly Nursing Assessments and IHCPs. The monitoring team attended the ISP held for Individual #65. The meeting was well attended by the individual's support team, representatives from the school system, and two RN Case Managers (one was new, the other was the preceptor for the RN Case Manager). The RN Case Manager was familiar with many aspects of the individual's needs. However, it was discovered that the individual vocalized his dislike for certain dietary supplements during the meeting. This was an indication that more work was needed to ensure teams are effectively reviewing the assessments, and that the assessments accurately reflect the individual's preferences. Even though this finding was quickly addressed by the attending physician to make adjustments for his personal preferences, his support staff should had addressed it prior to the meeting. Based on a review of the IRRFs/IHCPs for Individual #745, Individual #702, Individual #885, Individual #972, Individual #988, and Individual #628: • Five of five (100%) IHCPs indicated they were approved by the IDT within 14 days. The format, however, was flawed because the actual date the plans were implemented could not be determined.	Noncompliance

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		• Four of five (80%) risk assessments provided adequate clinical data to accurately determine risk. • Three of five (60%) IHCPs were sufficiently integrated among all appropriate disciplines. • Three of five (60%) IHCPs contained functional and measurable goals in the ISPs to measure the effectiveness of the plan • Three of five (60%) IHCPs identified appropriate health indicators to be monitored and the frequency of monitoring. For example, Individual #745's IRRF documented cardiac risk as high and circulatory as low, even though he had a documented diagnosis of hypertension, hyperlipidemia, and hypertriglyceridemia. The IRRF documented weight as medium risk, however, the action steps did not include frequency of observations, when he was making poor choices or overeating, or ways to assist specific disciplines with plans for addressing underlying reasons. The record indicated monitor weigh PRN, without specific perimeters. A review of completion of the IRRFs 10 days prior to ISP assessment, showed an average of 87% from September 2013 through March 2014. Even though there was improvement in the IRRFs, the IHCPs continued to be a challenge for the inclusion of substantial information for the interventions for the plans reviewed. The monitoring team also randomly reviewed, onsite, individual notebooks on each unit for Individual #892, Individual #885, Individual #554, Individual #377, and Individual #790. The monitoring team found: • Five of five (100%) contained a copy of the individual's current ISP, IHCP, and staff instructions. Even so, the IHCP and staff instructions were problematic for discerning a date of implementation, and dates staff were actually trained on the staff instructions (e.g., Individual #885). The facility self-rated noncompliance specific to quality. The monitoring team was in agreement. Nursing should continue its momentum in the timely completion of IRRFs and its own ongoing practice of collaborative team interventions, oversight, and mentoring practices. The facility should continue to build upon the risk process as a multidisciplinary team to address fragmented processes (e.g., assessment/addressing risk and the development of plans of care, outcomes that are realistic, measurable and obtainable by the individual).	

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M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	<u>Medication Administration Training</u> • The facility did have a Medication Administration Training program developed in accordance with current, generally accepted professional standards of care. • 2014 Annual Medication Administration Positioning Training for Nurses (100% trained) <u>Monitoring Team's Medication Administration Observations</u> Based on the observations by the monitoring team on each of the five units; for 13 oral, one topical, and three enteral medications for 17 individuals. The individuals were Individual #285, Individual #38, Individual #432, Individual #297, Individual #716, Individual #639, Individual #591, Individual #568, Individual #875, Individual #150, Individual #101, Individual #792, Individual #119, Individual #863, Individual #479, Individual #557, and Individual #197 • 17 of 17 (100%) were provided privacy during medication administration, either in a private room or shielded with privacy screens. • 17 of 17 (100%) individuals were identified. • 17 of 17 (100%) observations found medications were administered according to prescription in terms of the eight rights. • 17 of 17 (100%) observations found each medication was checked against the MAR, prior to administering. • 17 of 17 (100%) observations found each medication adhered to the applicable facility's Medication Observation Tool, for essential requirements • 17 of 17 (100%) individual's DSP staff consistently assisted the nursing staff by bringing one person up at a time for those receiving oral medications, and assisted with the nurse with positioning with individuals receiving medications via tube, and topical. • 12 of 12 (100%) individuals receiving oral medications participated or were assisted to participate in his or her own hand hygiene prior to administration of medications. • Eight of eight (100%) nurses followed infection control practices when administering medications. • Eight of eight (100%) nurses followed administering medications consistently followed generally accepted safe medication practices for oral, topical, and enteral routes of medication administration. Based upon review of MARs of those individual observed during medication administration: • 17 of 17 (100%) of MARs showed that all prescribed were administered as prescribed. • 17of 17 (100%) of these MARs did not contain omissions (blanks). • The monitoring team, after the medication pass, questioned the nurse regarding nursing policy/procedure, of which eight of eight (100%) of the nurses provided correct responses. In addition to these observations the monitoring team observed: • Nurses followed nursing policy/procedure/protocol when troubleshooting a clogged tube	Substantial Compliance

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		that included an immediate notification to the physician. • Nurses followed nursing policy/procedure/protocol when assessing the pressure area prior to applying the prescribed topical medication (Duoderm) to the pressure area. <u>Documentation</u> Based upon MARs from record sample of 17 individuals: • 16 of 16 (100%) individual's MARs, receiving oral/enteral medicine record sample showed that all prescribed medications were administered as prescribed and initialed. • One of one (100%) topical was documented on the appropriate treatment record. Facility's Medication Observation Passes Audit Report October 2013 through March 2014 showed an overall compliance of 99.92%. <u>Storage and Security of Medications</u> Based on the observations by the monitoring team of five medication rooms and five medication carts: • Five of five (100%) showed they were clean and free from clutter. • Five of five (100%) medication carts were locked and when not in use, were in the direct control of the nurse. Only the nurse assigned to administer medication had access to the medication cart. • Five of five (100%) of the medication rooms refrigerator temperature logs showed they were checked and documented daily for proper temperature control. The facility conducted Medication Room Audits. • The facility's Medication Room Audits, November 2013 through March 2014, showed an overall compliance of 97.40%. <u>Oversight and Monitoring</u> The facility did have a formalized process for capturing, tracking, analyzing, and trending each of the following: • Medication administration training • Medication administration observations audits • Medication room audits • Medication administration variances <u>Medication Variances</u> Based on a review of 10 medication variances by the monitoring team, for Individual #533, Individual #293, Individual #1 (two), Individual #466, Individual #233, Individual #195, Individual #395, Individual #659, and Individual #284. • 10 of 10 (100%) medication variances contained corrective actions that included	

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		supporting the nurse through mentoring • 10 of 10 (100%) described how the variance occurred • Nine of 10 (90%) contained the date and time of notification to the physician • Four of seven (57%) for the node administering, were discovered within 24 hours The MERC Committee meeting, attended by the monitoring team, presented its longitudinal medication data, and explanation for any spikes/changes in their data. The facility continued to maintain a robust database for a method for reporting for each type and number of medication variances. In addition, the monitoring team attended a weekly meeting, which followed one of the Clinical Morning meetings, to review new medication variances. The facility's multidisciplinary team included Nursing, Medical, and Pharmacy directors. The review included an in-depth discussion regarding the completeness of the four variances, the magnitude of the error, actions taken, and additional systemic corrective actions for Individual #619 and Individual #591, who had three variances. For more information on medication variances see Section N. The facility's self-assessment documented they were in substantial compliance with M6. The monitoring team found the facility had sustained substantial compliance and continued to improve upon its practices and processes that: • Demonstrated consistent safe medication administration practices • Produced solutions to prevent the migration of harm when risks are identified • On an immediate basis, consistently monitored, and reported to improve care, reduce imminent risk to others, and provide a more accurate record of events. • Developed prevention strategies	

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, 4/24/14 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, December 2013- June 2014 o Medication Variance Review Committee Meeting Notes, December 2013 – April 2014 o Medical review Committee Meeting Summaries, November 2013- April 2014 o Polypharmacy Committee Meeting Minutes, 2014 o Clinical Interventions Reports, November 2013 – March 2014 o Review of Physician Orders Reports, November 2013 – March 2014 o Adverse Drug Reactions Reports, o Drug Utilization Calendar o Drug Utilization Evaluations • Lisinopril • Primidone o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #121, Individual #98, Individual #873, Individual #990, Individual #235, Individual #331, Individual #541, Individual #266, Individual #591, Individual #470, Individual #876, Individual #612, Individual #117, Individual #511, Individual #154, Individual #297, Individual #533, Individual #540, Individual #901, Individual #92 Individual #568 Individual #589, Individual #170, Individual #414, Individual #702, o MOSES and/or DISCUS Evaluations for the following individuals • Individual #263, Individual #703, Individual #15, Individual #192, Individual #31

	Individual #121, Individual #554, Individual #816, Individual #988, Individual #235, Individual #332, Individual #885, Individual #401, Individual #287, Individual #69, Individual #589, Individual #330, Individual #591, Individual #1, Individual #518, Individual #178, Individual #257, Individual #377, Individual #120, Individual #225 Individual #839, Individual #462, Individual #971, Individual #800, Individual #792, Individual #612, Individual #117, Individual #511, Individual #154, Individual #297, Individual #533, Individual #540, Individual #901, Individual #92, Individual #568 Interviews and Meetings Held: o Ann Swartz, RPh, Pharmacy Director o Ricarda Price-Burke, RPh, Staff Pharmacist o Abigail Okeke, PharmD, Clinical Pharmacist o Thana Dhanaphibul, PharmD, Staff Pharmacist o Christopher Ellis MD, Medical Director o James Gilley MD, Primary Care Physician o Admerle Hoskins-Hall, 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 Norris Buchmeyer, Chief Nurse Executive o Karen Wilson RN, QA Nurse Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Reduction Committee Meeting o Polypharmacy Oversight Committee Meeting o Daily Clinical Services Meetings o Medical Review Committee Meeting
	Facility Self-Assessment: MSSLC submitted three documents as part of the self-assessment process: self-assessment, action plan, and the provision action information. For each of the provision items, the facility lead listed the activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. The activities were similar to the activities conducted for the last compliance review. Some of the activities resulted in information similar to that reviewed by the monitoring team. 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. The facility rated itself as being in substantial compliance with provisions N3, N4, N6, and N7. The monitoring team found the facility in substantial compliance with provision N4 and N7.
	Summary of Monitor's Assessment: The provision of pharmacy services was impacted by significant changes in the pharmacy department. The department had a new director who assumed the position on 2/14/14 to fill the vacancy made by the previous director who left earlier that same month. The new director began working as a staff pharmacist at MSSLC in May 2013. There was also a new staff pharmacist who began employment on 5/16/14. At the time of the compliance review, the department was fully staffed with two full time staff pharmacists, one clinical pharmacist, four pharmacy technicians, a clerk, and a pharmacy director. Communication between the pharmacists and prescribers continued and there was documentation of this communication. The documentation provided information about prescribing issues, but that information did not appear to be utilized for the purpose of performance improvement as had been seen in previous reviews. The staff pharmacist completing the documentation appeared to be the only staff aware of the types of interventions that were being documented. Compliance with timely completion of the QDRRs was gradually improving, but compliance rates had dropped to such low rates that reaching an acceptable compliance rate will require vigilance on the part of the pharmacy staff. Monitoring for metabolic syndrome continued to present challenges for the facility. The facility utilized the appropriate ATP III criteria inclusive of the criterion related to medication use for treatment of hypertension and hyperlipidemia. Moreover, documents reviewed noted that the medical department recently implemented the requirement to obtain fasting blood glucoses quarterly for individuals who received psychotropic medications. Even so, individuals who potentially had the diagnosis of metabolic syndrome were not thoroughly reviewed to make a final determination regarding the presence of the diagnosis. The use of AVATAR seemed to serve as a barrier to completion of the MOSES and DISCUS evaluations. The evaluations could be fully completed electronically with AVATAR, but consistent adequate completion was not seen. There was progress seen in the medication variance system. Processes were implemented to ensure the accuracy of data through collaboration between medical, pharmacy, and nursing. The nursing department had done a substantial amount of work in many areas and provided evidence of corrective actions that occurred with staff. Similar efforts were needed in the medical and pharmacy departments. Adverse drug reactions were reported, usually by the clinical pharmacist. However, the facility's ADR

	policy and procedure was not followed and ADRs were receiving essentially no review by the Pharmacy and Therapeutics Committee, which was assigned oversight for the process. Two DUEs were completed, but the first did not occur within the required timeframe. Finally, every provision item in this section should be discussed directly or indirectly in the Pharmacy and Therapeutics Committee meeting. An organization's Pharmacy and Therapeutics Committee serves to provide oversight and take action on issues related to the Medication Use System. This encompasses a broad range of activities including, but not limited to review of formulary issues, marketplace status (e.g., medication recalls, FDA updates), medication safety issues, DUEs, ADRs, medication variances, clinical interventions, microbial resistance and sensitivity data, and medication related policies and procedures. The responsibility charged to this committee requires that it conduct meetings on a regular basis. The facility conducted a Pharmacy and Therapeutics Committee meeting on 12/10/13, which was the week of the last compliance review. The next meeting was held on 4/29/14. This was nearly five months after the previous meeting. Per policy, meetings were required quarterly. The pharmacy and medical directors must ensure that these meetings occur within the appropriate timeframe. The monitoring team attended the meeting held during the week of the compliance review. As an important and essential health care committee, this meeting will need to focus on the core responsibilities. The meeting attended by the monitoring team was brief and did not include the appropriate review of ADRs and other essential topics. As noted in the December 2013 compliance report, the facility must have a process for ensuring that prescribers receive information related to FDA Alerts, drug recalls, etc. The importance of this committee in issues related to medication safety requires that minutes be prepared and maintained in the permanent records of the facility. Minutes should include attendance, acceptance of previous meeting minutes, old business, new business, problems identified, actions taken, and follow-up activities. The chairperson should sign the minutes.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with	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. The pharmacy director reported that the review of physician orders and clinical interventions were not documented separately. Documentation reviewed by the monitoring team indicated that that the practice of documenting physician order reviews and clinical interventions separately continued. The staff pharmacist also reported during interviews that the information on physician order reviews was forwarded to	Noncompliance

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	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.	nursing. While there was no change in how the communication was documented, there was a significant difference in how the information was utilized. In the past, the department maintained data related to the number and types of prospective reviews. Per the facility pharmacy services policy, "the review of physician orders and clinical interventions would be discussed monthly with the medical team." During past reviews, there was documentation in the Pharmacy and Therapeutics Committee meeting minutes of such discussions. The monitoring team also observed discussions during the MRC meetings. This practice was noted to decline during the December 2013 review and the untoward consequences of that failure were noted and documented in the monitoring report. The pharmacy director reported that she was not aware of the requirement to discuss clinical intervention data with the medical team. Therefore, she did not maintain any data on the number and types of clinical interventions and review of physician orders. As a result of this, there was no documentation in the Pharmacy and Therapeutics Committee meeting minutes or the Medical Review Committee meeting notes related to clinical interventions. Summary logs were no longer maintained. The monitoring team reviewed the clinical intervention forms, physician review order forms, and supporting documentation. 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: • 11/14/13: Clinical intervention related to DDI between lithium and ibuprofen. Acetaminophen was recommended. The individual had a documented aspirin allergy. The recommendation was denied. • 11/14/13: Clinical intervention related to a severe DDI with lithium and Naprosyn. The recommendation was denied. • 12/9/13: Clinical intervention related to prescribing Allegra 180 mg BID. The maximum recommended dose is 180 mg daily. The recommendation was denied • 1/8/14: Clinical intervention related to lithium and Naprosyn. The recommendation was denied. • 1/10/13: Clinical intervention for Zantac 300 mg bid. The maximum dose is 300mg daily. The recommendation was denied. • 1/16/14: Clinical intervention for a Tamiflu BID for prophylaxis. The recommendation was accepted. • 3/27/14: Clinical intervention - Individual started on lamotrigine on 3/6/14; Claritin was started on 3/24/14 for an allergic dermatitis. The PCP stated the skin rash was not related and no changes were made.	

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		• 3/25/14: Clinical intervention for new order received for phenytoin without a level ordered on admission. The PCP indicated that the individual had been on the medication. The CI form documented the need for follow-up, but no follow-up was noted on the form. 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. A number of the pharmacy recommendations were rejected by the prescribers. Many of these were related to drug-drug interactions and the recommendations were to simply adjust the dosing by a couple of hours to avoid the interactions. It is unclear why the prescribers rejected such recommendations. Another frequent clinical intervention involved the use of lithium and NSAIDs. The recommendation was usually to increase monitoring for lithium toxicity. The recommendation was usually declined. The monitoring team found this unusual since there was documentation in meeting discussions from the December 2013 compliance review in which the medical director cautioned all providers regarding the use of NSAIDs and lithium. There was also a number of interventions related to supra-therapeutic doses of medications, specifically doses that were twice the FDA recommended dose. One provider consistently prescribed the double doses even after recommendations were given by the pharmacist. As previously noted, this provision addresses two processes within the Medication Use System, prescribing and dispensing. In addition to the specific examples discussed above, there were several concerns related to the facility's systems: • The pharmacy faxed or emailed the drug monographs to the prescribers following telephone notification when a severe drug interaction was reported. There was no requirement for the prescriber to acknowledge, in writing, receipt of this information prior to dispensing the medications. It was also noted that drugs were dispensed when "contraindications" were documented. • The pharmacist sometimes documented that follow-up was needed, but resolution of problems was not always noted. • There did not appear to be any clear threshold for review by the medical director. That is, the pharmacist accepted the explanation of the prescriber, documented it, and dispensed the drug. • The issues documented through the prospective reviews were not assimilated and provided to the medical director, or discussed with the medical staff. This was required by pharmacy policy. Review by the medical director was a specific	

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		recommendation made in the last monitoring report. 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, potassium, statins, acetaminophen, and digoxin. The execution of the Intelligent Alerts continued to present challenges for the pharmacy department. During the December 2013 compliance review, it was noted that the Intelligent Alert report did not include entries for several important drugs, such as lithium, phenobarbital, dilantin, and potassium chloride. This was reported to be due to syntax errors. The pharmacy director reported that the problem had improved, but was not entirely resolved. Recent monthly reports continued to included multiple pages where drugs where listed with no dates, pharmacist, or justification. The pharmacy director did not know the significance of this finding. Moreover, it appeared that there was an ongoing problem with drugs not being captured in the IA Reports. Based on the IA Reports reviewed, there were no new orders for dilantin during the reporting period. However, there were clinical interventions for lab monitoring associated with <u>new dilantin orders</u>. In addition to the documentation of Intelligent Alerts, the monitoring team found it difficult to determine the effectiveness of the process. In some instances, the providers elected not to follow the guidelines. The medications were dispensed and the pharmacist noted that improved monitoring or follow-up was needed. This was noted on the clinical intervention forms. Documentation of follow-up by the pharmacist was not consistent. Overall, there was documentation of communication between the pharmacist and the prescribers. There was evidence that there were a number of troubling prescribing patterns that needed to be addressed with the medical staff, including the use of supra-therapeutic drug doses and the management of drug-drug interactions. The facility also needed to continue to work with state office to determine if problems persisted with the Intelligent Alerts module. Based on the unexplained blank items and continued lack of drugs on the reports, the system was not fully functional. <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	

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		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. 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. There should be some written acknowledgement that this information was received. 4. The pharmacy department must have a system to elevate issues to the level of the medical director if unresolved with the prescriber. Consideration should be given to establishing thresholds for such referrals. 5. 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. 6. The medical director must address the issues identified related to appropriate laboratory monitoring. 7. 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.	25 Quarterly Drug Regimen Reviews were evaluated to determine compliance with this provision item. In accordance with state policy, the QDRRs included reviews of allergies, the appropriateness of medications, rationale for therapy, proper utilization, duplication of therapy, polypharmacy, drug – drug/food/disease interactions, and adverse reaction potential. The facility had adopted the lab matrix as the set of monitoring parameters for drug use. This required monitoring related to labs, vital signs, and other diagnostics associated with drug use. For each medical condition, the clinical pharmacist cited the drug used and listed the associated monitoring parameters. In the case of laboratory values, the exact values and dates were usually provided. It was usually, but not always, noted if the value was high, low, or normal. Comments were found regarding blood pressures and heart rate for individuals receiving antihypertensive medications. A table listing all of the criteria for metabolic syndrome was included in the worksheets. Much of the information was included in the worksheets completed by the pharmacists. The comments section of the evaluations improved, but was still limited. 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	Noncompliance

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		often did not appear to be clinically related. For example, information, such as weight, BMI, and lipids continued to be presented separately and 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 are examples of issues that require additional attention from the clinical pharmacist:
		• Individual #98, 1/15/14
		  ○ This individual received multiple psychotropic medications and had multiple criteria for metabolic syndrome including the use of metoprolol for treatment of hypertension, triglycerides 237, and an abdominal girth of 42.5. Serum glucose levels were also elevated. The clinical pharmacist did not summarize these criteria or make any recommendations to the PCP to review the individual for the diagnosis of metabolic syndrome.
		• Individual #990, 4/9/14
		  ○ There was no formal recommendation related to Vitamin D monitoring.
		• Individual #39, 8/30/13
		  ○ The individual received new generation psychotropic medications and had criteria for metabolic syndrome, including triglycerides of 155 and HDL of 32. There was no abdominal girth documented. Serum glucose levels were borderline elevated. Again, the clinical pharmacist made no comment on these findings in relation to the risk for metabolic syndrome.
		• Individual #541, 1/17/14
		  ○ The comments on seizure control were contradictory. It was noted in one section that seizures occurred in the past 24 months, but the seizure charts documented zero seizures.
		• Individual #533, 8/14/13
		  ○ There were no comments related to the elevated TSH - 6.51
		  ○ It was documented that the individual was not at risk for metabolic syndrome. The individual had multiple risks.
		• Individual #92, 8/23/13
		  ○ The individual had three criteria for metabolic syndrome. The abdominal girth was 44 cm, hypertension was treated with medication, and the HDL was 29. The clinical pharmacist did not make any comments related to this. Three criteria are adequate to make the diagnosis. Therefore, the pharmacist should request that the primary provider review the data.
		• Individual #589, 9/9/13
		  ○ The individual's triglycerides were 266, HDL 34, and abdominal girth 42.	

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		There was no comment by the clinical pharmacist. • Individual #702, 9/25/13 o The individual had an abdominal girth of 53 and glucose of 103. The weight was not documented. It would be reasonable to recommend checking an HbA1c if not already done. 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." 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. Additional staffing changes resulted in a continued decrease in compliance rates. The pharmacy director was well aware of the deficiencies related to timeliness of completion of the QDRRs. The overall compliance with timely completion for the months of October 2013 to March 2014 was 28.7%. Compliance scores began to gradually increase after plummeting to 2.4% in February 2014. The compliance in May was 11.4%. The pharmacy director had implemented a corrective action plan to address the deficiency. <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 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 in addressing the issue of 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	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	Noncompliance

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	substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	continued to comment upon polypharmacy for management of conditions, such as seizure disorder and constipation, in addition to psychotropic medications. 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 were made on the presence of management plans. <u>Monitoring Metabolic and Endocrine Risk</u> The facility monitored individuals for the metabolic risks through the QDRRs. The QDRR worksheet included a table that listed criteria for diagnosis of the metabolic syndrome, including waist circumference, triglycerides, HDL, blood pressure, and fasting glucose. The worksheet noted at the bottom of the table that the use of medication for treatment of hyperlipidemia and hypertension was a criterion. Per the MRC notes dated 4/2/14, fasting blood glucoses were done quarterly, but the lab matrix still indicated that testing was annually or as clinically indicated. The QDRRs continued to fail to adequately address the issue of metabolic syndrome. Individual parameters were cited in the comments section of the report. However, the clinical pharmacist did not synthesize the information into a cogent statement regarding the overall risk. Thus, there were several individuals who had multiple criteria for metabolic syndrome, but the clinical pharmacist did not make any specific recommendations to the primary care providers to review this information. Examples are provided in section N2. Inclusion of the medication criteria in the table may be helpful in identifying individuals with the possible diagnosis of metabolic syndrome. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. In order to move towards substantial compliance, there must be evidence that the monitoring for the metabolic and endocrine risk occurs in accordance with facility guidelines. The clinical pharmacist must not simply indicate that the individual is at risk. When multiple criteria are met, they should be identified and the pharmacist should document the criteria and make a recommendation to the PCP to review the individual's data.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical	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 <u>prospective and retrospective</u> reviews.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Prospective Recommendations Prospective recommendations were generated at the time new orders were written. As discussed in section N1, prescribers sometimes 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 explanations for rejection of recommendations on the clinical intervention and the physician order notification forms. 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. The prescribers usually documented adequate explanations on the QDRR report when the recommendations were not accepted. Compliance Rating and Recommendations This provision remains in substantial compliance. The medical director must address the documentation of rejection of prospective recommendations; specifically those that involve severe drug interactions and contraindications. 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. 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. A sample of the most recent MOSES and DISCUS evaluations submitted by the facility as well as the most recent evaluations included in the record sample was reviewed. The findings are summarized below: Thirty-nine MOSES evaluations were reviewed for timeliness and completion: • 34 of 39 (87%) were signed and dated by the prescriber • 21 of 39 (23%) documented the prescriber review • 11 of 39 (28%) documented "noted" or other comments	Noncompliance

#	Provision	Assessment of Status	Compliance
		• 7 of 39 (18%) documented no prescriber review (blank) Thirty-eight DISCUS evaluations were reviewed for timeliness and completion: • 28 of 38 (73%) were signed and dated by the prescriber • 29 of 38 (76%) indicated no TD • 4 of 38 (10.5%) documented "noted" or other comments • 5 of 38 (13%) documented no prescriber review (blank) The facility had implemented the use of AVATAR for completion of the MOSES and DISCUS evaluations. Thus, all evaluations were recorded electronically. Several formats for the prescriber review were observed. This final component of the evaluation was either completed electronically or handwritten by the psychiatrists. The electronic versions were usually appropriately completed. The handwritten versions varied as the comments were often not consistent with the required prescriber review. Some evaluations did not document a prescriber review or any relevant comments. Those evaluations simply included comments such as "noted" along with the physician's signature. There was variation even among the evaluations with electronic prescriber reviews. Several evaluations appeared to include a prescriber review as an additional report or addendum. The variation and inconsistency in formats was evidence that that facility had not determined how to fully utilize AVATAR to complete the evaluations. This resulted in an average of 15% of evaluations being incomplete and 19% being inadequately completed. Each QDRR noted the date of the most recent MOSES and DISCUS evaluations. For the QDRR sample reviewed, 21 of 25 (84%) indicated that the evaluations were current. MOSES and DISCUS data submitted for document section VII was not very useful in determining the overall compliance score for timely completion of the evaluations. Consideration should be given to how these data are tracked. 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. One primary provider was noted to include the information in the annual assessments. Overall, the information was not utilized by the primary providers or reviewed by the campus neurology consultant. The monitoring team has, and continues to, recommend that the primary care providers and neurology consultants review this information. They should be provided evaluations that have been appropriately completed inclusive of the prescriber review.	

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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><u>Compliance Rating and Recommendations</u>
The monitoring team agrees with the facility's self-rating of noncompliance primarily due to the failure to adequately complete the prescriber review component of the evaluations. To move in the direction of substantial compliance, the facility must take several actions:
1. The evaluations must be fully and adequately completed in a timely manner.
2. The information must be utilized in clinical decision-making.
3. The data <u>must be reviewed by the primary providers</u> in addition to being reviewed by the psychiatrists and neurologists.</td><td></td></tr>
<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. 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">Suspected Adverse Drug Reactions Reported 2013 - 2014</td></tr>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td></tr>
<tr><td>Number of ADRs</td><td>3</td><td>4</td><td>3</td><td>8</td><td>10</td><td>10</td></tr>
<tr><td>% Reported by Medical Staff</td><td>33</td><td>25</td><td>0</td><td>25</td><td>10</td><td>--</td></tr>
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The average number of suspected ADRs documented monthly for the reporting period was 5.8. This was similar to the average of 6.3 seen in the previous compliance review. The majority of the ADRs were detected by the clinical pharmacist while completing the QDRRs. In stands to reason that it would be preferable for suspected ADRs to be reported as soon as possible. This will require increased vigilance on the part of the medical staff. For example, the primidone DUE highlighted that there were a number of possible adverse drug reactions, but no ADR reports were submitted. One individual was hospitalized with a possible seizure after starting primidone, but no report was submitted. If primidone was considered to be linked to the seizure, this case should have been further reviewed. One of the DUE recommendations was to explore suspected primidone associated ADRs.

The monitoring team has stated in past reports that one caveat of using the current FMEA Risk Priority Number is that the threshold allowed cases in which individuals who experienced with serious ADRs resulting in hospitalization to escape further review. The monitoring team suggests that the pharmacy director review alternative severity scales, such as a modified Hartwig scale. This is independent from the use of the Naranjo scale, which assesses causality.

Problems with the ADR program extended beyond the lack of physician reporting and</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		development of a severity threshold. The basic framework of the program had shifted almost entirely under the auspices of the Medical Review Committee. Weekly review of the ADRs with the clinicians expedites clinical decision-making and care. Such reviews do not eliminate the need for review by the Pharmacy and Therapeutics Committee. ADRs were not adequately reviewed in the P & T meeting attended by the monitoring team. Minutes of the previous meeting also reflected a lack of the appropriate review. The pharmacy director reported that ADRs were thoroughly discussed in the MRC meetings. However, as noted in previous reviews, the documentation of the MRC meetings was not complete. Summaries and not minutes of the meetings were produced. A list of topics for discussion was submitted similar to an agenda, but there was no actual documentation of the outcome of the discussion. Therefore, the Medical Review Committee did not provide adequate documentary evidence of the discussion of the ADRs. Moreover, per facility policy, the Pharmacy and Therapeutics Committee was responsible for the oversight of the ADR reporting and monitoring program. This is standard practice within a health care organization since the P&T Committee membership typically includes members of the medical staff, pharmacists, nursing executives, facility administrators, and quality managers. The committee's role relative to the ADR reporting and monitoring program is to (1) ensure that data are appropriately analyzed for trends and serious ADRs are identified, (2) support and promote educational activities related to ADRs, and (3) monitor the effectiveness of the program. The ADR program should be incorporated into the agency's overall quality and risk management programs. <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. There should be follow-up of the primidone data including the hospitalization. 2. The P&T Committee must review ADR data, analyze the data for patterns or trends, and develop 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 should consider the use of alternative severity threshold such as the Hartwig ADR severity threshold. 5. The pharmacy director will need to develop a review a process for the ICA. The goal is to conduct a through multidisciplinary review, of cases that meet a pre-determined threshold, of the circumstances and systems surrounding the event using appropriate methodology. 6. The facility will need to review the ADR policy and the various levels of review	

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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>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 Lisinopril was completed and presented on 4/29/14 at the Pharmacy and Therapeutics Committee meeting. The previous Pharmacy and Therapeutics Committee meeting was conducted 20 weeks earlier on 12/10/13. Per policy, quarterly meetings were required. The DUE report documented the study dates as January through March 2013. The audit tools, completed by a facility RN, indicated that the chart audits were conducted on 4/27/14 and 4/28/14. Completion of the Lisinopril DUE did not meet the requirements for completion of one DUE each quarter because the previous DUE was presented on 12/10/13.

A DUE on the use of primidone was presented at the P&T Committee meeting held during the week of the compliance review. Both the Lisinopril and primidone DUEs included the objective, methodology, and results of the evaluation and recommendations. There were no corrective action plans associated with either DUE.

<u>Compliance Rating and Recommendations</u>
This provision will remain in substantial compliance at this time. In order to maintain substantial compliance, the facility must complete DUEs within the appropriate timeframe and present the evaluations in a timely manner to the Pharmacy and Therapeutics Committee. Per policy, the Pharmacy and Therapeutics Committee must approve the audit tools and data collection methodology. The P&T Committee minutes should document the discussions, corrective actions, and follow-up.</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. The medication data provided to the monitoring team are summarized in the tables below.

<table>
<tr><td colspan="7">Medication Variances 2013 -2014</td></tr>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td></tr>
<tr><td>Nursing</td><td>24</td><td>51</td><td>88</td><td>37</td><td>34</td><td>26</td></tr>
<tr><td>Pharmacy</td><td>19</td><td>14</td><td>43</td><td>39</td><td>72</td><td>66</td></tr>
<tr><td>Medical</td><td>10</td><td>15</td><td>10</td><td>8</td><td>7</td><td>9</td></tr>
<tr><td>Total</td><td>53</td><td>80</td><td>141</td><td>84</td><td>113</td><td>101</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. The monitoring team was informed that a number of changes occurred since the last compliance review that contributed to the decrease in nursing errors.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		• Environmental issues had been addressed. • A two-nurse process was used to verify new orders. • Nursing had worked with the medical staff to clarify start times for medications. There was a marked increase in the number of pharmacy dispensing errors. This was attributed to one of the staff, and the pharmacy director indicated the problem was resolved. The pharmacy did not report internal errors. That is, the pharmacy director did not document errors that were made within the pharmacy and were detected prior to the medications being physically dispensed from the pharmacy. It would seem that this would be important because data on internal errors has the ability to provide important information on the internal pharmacy processes as well as performance of the employees. Prescribing errors were reported, but the monitoring team observed that the medical department did not have specific corrective action plans to address medication variances. Other than addressing the requirement to document medication allergies, the Medical Review Committee minutes did not document discussion of the physician prescribing errors. This was somewhat concerning because the clinical interventions documented some problems related to physician prescribing patterns. This is discussed in section N1. Overall, progress was seen in the medication variance system: • Medical, pharmacy and nursing representatives were reviewing variances to appropriately assign the level of variances and ensure greater reliability of variance classification. • Nursing variances were trending downward. • There was improved reporting of prescriber variances. • There was improved reconciliation of pill medications. Continued progress will require that the facility address some outstanding issues: • A process needs to be developed to reconcile non-pill medications. • Appropriate corrective action plans are needed for prescribing variances. The issues discussed in section N1 related to supra-therapeutic doses and allergies should also be discussed with providers. • The pharmacy should monitor its internal errors and take appropriate corrective actions. <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 to work on all aspects of the medication use system,	

#	Provision	Assessment of Status	Compliance
		ensuring that best practices are in place and agency and state policy is being followed. 2. 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. 3. Address the issues noted above.	

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 PNMT Staff list, back-ups, and Curriculum Vitae o Staff PNMT Continuing Education documentation o List of Medical Consultants to PNMT o Section O Presentation Book and Self-Assessment o Section O QA Reports o PNM spreadsheets submitted o PNMT Evaluation template o PNMT Meeting documentation submitted o Daily Provider 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 and documentation for the following: Individual #216, Individual #314, Individual #310, Individual #80, Individual #577, and Individual #395. o PNM spreadsheets o Individuals with PNM Needs o Completed PNMP 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 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 List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Fractures

	○ Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months ○ Individuals With Falls Past 6 Months ○ List of Individuals with Chronic Respiratory Infections ○ List of Individuals with Enteral Nutrition ○ List of Individuals with Fecal Impaction ○ Individuals Who Require Mealtime Assistance ○ List of Choking Events in the Last 12 Months ○ Individuals with Pressure Ulcers and Skin Breakdown ○ Individuals with Fractures Past 12 Months ○ Individuals who were non-ambulatory or require assisted ambulation ○ IRRFs for Individual #533, Individual #435, Individual #528, Individual #341, Individual #35, Individual #188, Individual #285, Individual #80, and Individual #395. ○ PNMT Assessments and ISPs submitted for Individual #524, Individual #293, Individual #395, Individual #80, Individual #888, Individual #577, Individual #43, Individual #117, Individual #441, and Individual #629. ○ Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #43, Individual #432, Individual #188, Individual #395, Individual #503, Individual #524, Individual #80, Individual #629, Individual #376, Individual #407, Individual #597, Individual #197, Individual #117, Individual #441, Individual #888, and Individual #577. ○ PNMP section in Individual Notebooks for the following: • Individual #43, Individual #432, Individual #188, Individual #395, Individual #503, Individual #524, Individual #80, Individual #629, Individual #376, Individual #407, Individual #597, Individual #197, Individual #117, Individual #441, Individual #888, and Individual #577. ○ Dining Plans for last 12 months, Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #43, Individual #432, Individual #188, Individual #395, Individual #503, Individual #524, Individual #80, Individual #629, Individual #376, Individual #407, Individual #597, Individual #197, Individual #117, Individual #441, Individual #888, and Individual #577. <u>Interviews and Meetings Held</u>: ○ Sandra Opersteny, PT, Habilitation Therapies Director ○ Lisa Finley, COTA ○ Various supervisors and direct support staff

	Observations Conducted: o Living areas o Dining rooms o Day program areas o ISP for Individual #557 o Pre-ISP for Individual #497
	Facility Self-Assessment: The self-assessment completed by Sandra Opersteny, PT, Habilitation Therapies Director, and Lisa Finley, COTA, was improved from the last review. Activities listed as conducted were relevant. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of elements were addressed and used to determine compliance. Findings were consistently reported in measurable terms, though there were inaccuracies and inconsistencies identified by the monitoring team. Though the self-assessment was apparently created for the monitoring team, this should be a process used by the department to track and determine progress with the elements of the Settlement Agreement and to direct the necessary actions for the department in order to effectively focus staffing, administrative supports, and oversight. 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, in general, continued to demonstrate hard work, though there was limited overall progress related to the elements of Section O. The department leadership rated itself in substantial O.1 and O.3 and noncompliance with O.2 and O.4 through O.8. The monitoring findings supported substantial compliance with O.1, O.4, and O.5. 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. The facility must address retention of clinical staff for continuity of the PNMT. 2. The facility should review the system of the determination of who should attend the ISP during the pre-ISP. This was not consistently documented and many did not appear to consider a need to review the PNMP and other aspects of the individual's annual plans in these determinations. Attendance should then be consistent with these determinations. 3. Ensure better communication across Habilitation Therapy professionals for improved representation at the ISPs/ISPAs. 4. All designated changes to the PNMP identified in the ISP/ISPA must be made and implemented within 24 to 48 hours for critical changes and no more than 30 days for changes that were not critical to health and safety. 5. Ensure that the PNMT assessments address the essential elements outlined above and that the information is presented clearly and succinctly. 6. Ensure that clinical indicators are well outlined to reflect improvement in health status relative to

	the efficacy of supports and services provided. 7. Review the current discharge criteria to drill these down to more discrete measures to ensure that individuals are re-referred to the team in a more timely manner rather than waiting for the same level of criteria (negative health outcomes) to re-occur before actions are taken. 8. Ensure that all recommendations and actions identified in the PNMT assessments are adequately documented in the ISPs, ISPAs, IRRFs, and IHCPs. 9. Ensure that assessment, discharge and other key elements of support from PNMT service are reflected in a discharge summary written by the PNMT and captured in the ISPA. 10. Consider a recommendation log to readily track completion of action steps or attempt to more accurately and consistently capture these in the meeting minutes for translation to the discharge summary when indicated. 11. The facility should ensure that the Mealtime Coordinator position is fully implemented across all homes for all meals. A focus on transfers and re-positioning should be considered during the next six months. Observations related to oral hygiene will be conducted during the next review. 12. Clarification of the staff who had successfully completed all competency-based training was needed. 13. As identified by the facility in the self-assessment, they are encouraged to move forward with the inter-rater reliability aspect for Mealtime Coordinators and for compliance monitoring. 14. Establish benchmarks, a tracking system, and schedule for compliance monitoring. It appeared that some monitoring was done, but there was no clear method to determine if all areas of the PNMP were addressed at an established frequency. 15. Ensure that compliance monitoring is consistently conducted related to all aspects of the PNMP at the recommended frequency. 16. Establish protocol related to the completion and use of comprehensive assessments by key IDT members, on an annual basis, to determine the medical necessity of all individuals with enteral nutrition. 17. Ensure that discussion related to medical necessity and return to oral intake are clearly documented in the ISP, IRRF, and IHCP, as appropriate. 18. 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.
	Summary of Monitor's Assessment: The facility maintained substantial compliance with section O.1 and achieved substantial compliance with sections O.4 and O.5. There continued to be a full PNMT, however, there were again all new members with the exception of the PT and the dietitian. Observation of the PNMT meeting revealed that the team members appeared to be working well together. In many ways, however, they were beginning from scratch to establish a system of PNMT assessments and supports and services. The minutes were organized and appeared to be well maintained. Areas that needed improvement were outlined and included establishing consistent due dates for actions and dates of completion in order to track timeliness. In addition, the actions should address more specific outcomes for individual supports rather than only

	administrative issues such as "complete PNMT assessment." The team was encouraged to review the individuals they were following to include specific clinical indicators and revise measurable criteria and discharge criteria. In addition, they should revisit the criteria for re-referral to the team because currently these were the same as the initial criteria. In other words, an individual has to experience two incidences of aspiration pneumonia in one year before a referral is accepted by the team. Once discharged, that same individual must experience another two incidences in a year before re-referral is considered. This did not demonstrate an understanding of the required sense of urgency and intensity required for PNM supports and services for individuals at high risk. Mealtimes continued to show improvements in both the Martin and Barnett units. The primary concerns were related to content in the Dining Plans that outlined specialized techniques. Staff were attempting to follow these instructions, but were not competent and skilled. Non-foundation training may be indicated in these cases because these would not be skills generally trained in NEO. Another area was related to recognizing the need for prompts and cues to slow down and take smaller bites. These types of concerns should be picked up through compliance and effectiveness monitoring system. Currently, monitoring was being conducted by therapy clinicians only, and a very limited number of these were related to mealtimes. PNMPCs did not conduct any monitoring, though there was a plan to reinstitute this in the near future. Positioning had also improved based on the observations by the monitoring team. In a few instances, the staff did not recognize the need to re-position the individuals and required prompting and instruction. This again should be readily identified and corrected through compliance and effectiveness monitoring. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 16 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. Sample O.3 consisted of individuals at MSSLC who received enteral nutrition, for whom IRRFs were submitted (9). Some of these individuals might also have been included in one of the other two samples.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner,	The facility used the state-approved PNM policy that addressed the broad scope of PNM issues outlined below. A MSSLC PNMT handbook was completed recently and this should be reviewed for accuracy and content to ensure that it outlined a complete and comprehensive system of Physical Nutritional Management. The following elements should be addressed in this handbook. Even so, each of the following elements were clearly in practice at the time of this onsite review: • Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); • The annual review process of an individual's PNMP as part of the individual's ISP; • 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; 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: o Definition of monitoring process to cover staff providing care in all	Substantial Compliance

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	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.	aspects in which the person is determined to be at risk, o 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), o Identification of monitors and their roles and responsibilities, o 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, o 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 o 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: • Linda Pritchett, RN (3/1/14) • Lisa Phillips, RD, LD (10/16/13) • Gloria Wells, MS, CCC-SLP (November 2010) • Deborah Adkins, OTR (4/2/14) • Sandra Opersteny, PT (6/3/1991, start date on the PNMT was not listed) This team had a number of new members since the previous review. In less than a year's time, all positions had changed with the exception of the PT. IDT therapists were designated as back-ups for each position for OT, PT, and SLPs. There were no back-ups listed for the dietitian or nurse. <u>Consultation with Medical Providers and IDT Members</u> All physicians, nursing case managers, a psychologist, and the Nutrition Supervisor were listed as the medical provider consultants to the team. One or more physicians attended (or participated by phone) in 17 of 21 PNMT meetings (81% over six months). This was a significant improvement from 54% in the previous review. The other medical providers listed as consultants did not attend meetings with one exception for one meeting	

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		(Nutrition Supervisor). • For 8 of 8 individuals (100%) for whom evaluations had been completed in the last six months, evidence was provided of efforts by the PNMT to seek participation by medical staff review of assessment or and/or participation in the analysis of findings. A physician had reviewed and signed each of these reports. While attendance at the meeting was an excellent method to gain the input of the medical staff, alternate methods to ensure their availability to the PNMT should also be established. IDT therapists served as back-ups to core team members. This occurred numerous times for all positions, with the exception of the dietitian, due to the extensive turnover in PNMT members. There was also consistent participation by the PNMT RD and PT who attended each of the quarterly Infection Control Committee meetings since 10/21/13 and each of the Skin Integrity Committee meetings since 12/9/13. These meetings addressed both individual-specific issues and systems issues. Daily medical provider meetings were held and one, and often two, PNMT members were present at 100% of these meetings for which minutes were submitted (12/6/13 through 4/25/14). This was an improvement from 93% in the previous review. Medical and IDT staff attended these meetings, and this served as an excellent forum to ensure timely communication with other team members related to the individuals served by the PNMT and to identify others who would benefit from these services. • For 21 of 21 PNMT meetings (100%) held from 12/5/13 to 5/1/14, there was evidence of participation by IDT members, including physicians, RNCMs, QIDPs, and therapy clinicians. This was a significant improvement from 0% in the previous review. In some cases, these professionals appeared to serve as back-ups to a core team member. Though IDT members routinely attended PNMT meetings, the PNMT also reviewed their findings in an IDT/ISPA upon completion of the assessment and attended IDT meetings related to individuals they reviewed or who were referred to the PNMT. This provided additional opportunities for collaboration in assessment, planning, implementation of interventions and actions, follow-up, and monitoring. These meetings were logged in the PNMT Meeting Attendance records for January, March and April 2014. According to this log one or more PNMT members attended 60 of 60 ISP/ISPA meetings. The PNMT Attendance log for February 2014 was not submitted. <u>Qualifications of PNMT Members</u> The qualifications of the current PNMT members were as follows: • 5 of 5 current core team members (100%) were currently licensed to practice in	

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		the state of Texas. • 4 of 5 core PNMT members (80%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. The dietitian was newly graduated (2011) and had limited experience. A very experienced dietitian supervised her and was available for consultation and, as such, this was not a concern to the monitoring team. Collectively, the five team members had over 100 years of experience in their respective fields and approximately 75 years with individuals with intellectual disabilities and/or complex medical needs. <u>Continuing Education</u> • 3 of 5 PNMT current core team members (60%) had completed continuing education directly related to physical and nutritional supports and transferable to the population served within the past six months. The exceptions were the SLP and the RN. Previous core team members had completed related continuing education, but were no longer a part of this team. 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: • Lisa Phillips, RD, LD (approximately 11 contact hours in the last six months) • Deborah Adkins, OTR (approximately 14.5 contact hours in the last six months) • Sandra Opersteny, PT, (approximately 8 contact hours in the last 12 months, over 130 in the last year) These included, but was not limited to, the following areas: • Seating, Mobility and Mat Assessment • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities • Skin Care and Management • Edema • Dysphagia • Nutrition Support • Diabetes 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 members, individually and collectively, via cross training. The facility is commended for supporting this critical aspect of PNM supports and services, and should ensure that all core team members participate in this invaluable education.	

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		PNMT Meetings • Since the last review, the PNMT met at least once for 21 of 22 weeks (95%) from 12/5/13 to 5/1/14 (based on meeting minutes submitted for that period). • Based on review of the minutes, attendance at the weekly meetings by core PNMT members and/or back-ups for the meetings conducted during this period was: o RN: 12/21 (57%) by core member, 7/21 (33%) by back-up, 90% overall o PT: 16/21 (76%) by core member, 3/21 (14%) by back-up, 90% overall o OT: 20/21 (95%) by core member, 1/21 (5%) for back-up, 100% overall o SLP: 7/21 (33%) by core member, 14/21 (67%) for back-up, 100% overall o RD: 21/21 (100%) by core member, 0/21 (0%) for back-up, 100% overall Absences for core team members without a back-up were noted only on 1/29/14 for the PT and on 1/3/14 and 3/20/14 for the RN. With the exceptions of OT and RD, attendance was below the criterion of 80% for the core team with 10% or less for back up with an overall percentage of 90%. This was a decrease from the previous review. Clearly, this was attributed to the significant turnover of clinicians over the last six months. With the exception of the RN and PT, attendance by a same-discipline back-up was noted to ensure 100% attendance. In the case of the RN and PT, this was slightly less at 90%. Of greatest concern, however, was the lack of a consistent core team SLP for only one third of the meetings and the RN for less than 60% of meetings. This negatively impacts team-building, collaboration, cross-training, and continuity. That said, the opportunity for IDT therapists to participate promotes capacity-building and education related to the PNMT process for application at the IDT level for other individuals served by the back-ups. • Since 12/5/13, all PNMT meeting minutes (100%) included (a) referrals, (b) review of individual health status, (d) PNMT actions, (e) follow-up, and (e) outcomes/progress toward established goals and exit criteria clearly outlined on a consistent basis. The meeting minutes were maintained and included the following elements: • Member attendance • Individual reviewed • Reason for referral • Current weight • EDWR • Discussion • Action Steps, Person Responsible, Due Date, and Date Done	

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		Elements not consistently addressed included: • Level of PNMT Involvement • Next review date • Though the facility had a system for resolution of systemic issues and concerns via Corrective Action Plans (CAPs), it was not clear that the PNMT had utilized this system to address concerns and issues identified during the last six months. For example, several systemic issues were identified during PNMT assessments, but these concerns were documented in a specific individual's ISPA. It was not clear that a CAP had been initiated to address these (for example, Individual #524). This system should address 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); o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan); o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and o 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. Section O requires that the PNMP be reviewed at the individual's annual ISP meeting and as often as necessary, approved by the IDT, and included as part of the individual's ISP. Also, the PNMP is to be developed with 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 facility self-rated continued substantial compliance with O.1, despite decreased core-team member attendance at the weekly meetings. However, given significant turnover, the facility had ensured fairly consistent attendance by a same-discipline back-up and there was significant improvement in attendance by the medical providers and IDT members. Thus the monitoring team found substantial compliance with O.1. However, to sustain this, the facility must address retention of clinical staff.	

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O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>Identification of PNM risk</u> Just over half of the individuals at MSSLC (55%) 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. Based on lists of individuals with identified PNM concerns, there were individuals who (a) required physical assistance for positioning associated with swallowing: 80 individuals, (b) were dependent on others to eat: 48 individuals (at least 28 individuals were enterally nourished), (c) had difficulty swallowing: 74 individuals (defined as individuals with altered diet texture due to dysphagia and those who received enteral nutrition), and/or (d) were considered to be at medium or high risk of choking (approximately 111 individuals) or aspiration (approximately 84 individuals). • Of those identified in any of these categories (collectively, "individuals having physical or nutritional management problems"), or approximately 112 individuals, 97% were listed with a PNMP. Those not listed with a PNMP included Individual #493 (high risk for aspiration) and Individual #324 (medium risk for choking) per document 1406-VI.2.h, dated 5/6/14. By report, however the risk levels had been decreased and, as such, it was determined that a PNMP was not needed for these individuals. Individual #63 was listed at medium risk for choking and was not listed with a PNMP. It was reported that he had been discharged on 4/30/14, though he was still listed in the risk lists. This did not include one individual identified with several of the PNM risks identified above and who was not listed with a PNMP, though was deceased at the time of this review. There were no choking events requiring abdominal thrusts (Heimlich) documented since the previous review. Documentation was submitted for two choking events (Individual #816 and Individual #231), though these occurred during the previous review period. <u>PNMT Referral Process</u> Per the MSSLC Physical Nutritional Management policy, individuals identified by the IDT who were at high risk as defined by the At Risk policy (#006) and for whom the IDT had been unable 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. The following criteria were listed in the PNM policy (adopted the state policy) as guidelines to the IDT for referral. Individual circumstances and risk levels dictated more or less stringent criteria per policy. 1. Two choking episodes in one year;	Noncompliance

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		2. Two Aspiration Pneumonia diagnoses in one year; 3. Results of PNMT Nurse Post-Hospitalization Assessment for individuals diagnosed with any of the following: a. Aspiration Pneumonia b. GI Issues c. Fractures d. Skin Integrity e. Seizures 4. New or proposed enteral feeding; 5. Unresolved vomiting (>3 episodes in 30 days not related to viral infection); 6. Significant/unplanned/verified weight loss or gain of: a. >5 pounds in one month; b. 3 or more pounds per month for 3 consecutive months or 7.5% of body weight for 3 consecutive months; or c. 10% of body weight in 6 months; 7. Any stage III or IV decubitus, or any stage II with delayed healing; or 8. Fracture of a long bone, spine, or hip. A Follow-up Tracker was submitted for individuals followed by the PNMT, as well as a Status Post Hospitalization Log. A number of these critical PNM issues, however, would not always be related to a hospitalization and the episode tracker should review key events for individuals not yet referred or followed by the PNMT. A log that identifies individuals with key events, in at least the above categories, will assist the PNMT to identify individuals who have reached referral criteria, but had not been referred. There were no criteria related to falls that warranted a referral to the PNMT. There were a significant number of falls in the last six months for Individual #494 (9), Individual #451 (6), Individual #31 (12), Individual #1 (5), and Individual #377 (11). A Status Post-Hospitalization Log tracked hospitalizations for PNM-related concerns, the completion of the PNMT RN Post-Hospitalization Assessment, and whether a PNMT referral had been generated. It would be critical to include this in the episode tracker, but there would likely be additional events that warranted review or discussion by the PNMT that may not have resulted in an actual hospitalization. These events would be identified through a variety of methods, most consistently through the Medical Provider meetings held daily and attended by PNMT representatives. Events should be tracked and documented as they occurred, to trigger the team to recognize when an individual was near threshold or at threshold for particular criteria that warranted referral. This would ensure prompt identification and action by the team.	

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		There were nine individuals listed on the current active caseload for the PNMT (Individual #629, Individual #197, Individual #43, Individual #376, Individual #503, Individual #524, Individual #395, Individual #293, and Individual #117). Discharge criteria were established via the assessment and at the time they were met, transition from the PNMT to the IDT was planned, including monitoring and re-referral criteria. Individuals in Sample 0.1 were reviewed for incidence of the concerns identified as requiring PNMT referral since August 2013. There was inconsistent evidence of ISPAs during which the IDT identified a need to make a referral within five days. Some examples follow: • Individual #524: She experienced a long bone fracture (left tibia) on or around 2/22/14. An ISPA was held on 2/24/14 to address this incident. There was no evidence that the IDT discussed a need for referral to the PNMT. The PNMT meeting minutes reflected discussion and a doctor's order for total bed rest for eight weeks. It was stated that they needed a meeting related to her. On 3/6/14, the PNMT meeting minutes again reflected that a meeting was needed to request a referral. Finally on 3/13/14, the minutes reflected a self-referral on 3/11/14, though there was no evidence of this in an ISPA. Several IDT meetings were held to review supports, but it was not until 3/19/14 that there was evidence in the ISPA of PNMT involvement. Additional meetings were held with PNMT representatives present through 4/15/14, but any assessment or supports provided by that team were not documented in the ISPA. On 4/25/14, the PNMT met with the IDT to present their assessment, two months after the incident. • Individual #197: He was diagnosed with pneumonia and there was an ISPA to discuss this on 11/1/13. There was no evidence of a PNMT referral at that time. On 11/20/13, it was reported by the PNMT RN that this had likely been aspiration pneumonia, but again there was no evidence of referral in the ISPA. On 3/27/14, there was a post-hospitalization meeting held relative to a second episode of pneumonia, but it was documented that no referral to the PNMT would be made, but without any rationale. The date of referral to the PNMT was 4/9/14, yet there was no ISPA related to that referral. • Individual #577: He was diagnosed with pneumonia and discharged from the hospital on 12/9/13. An ISPA was held on that date and the IDT determined that he would be referred to the PNMT. On 12/18/13, he was again hospitalized for pneumonia with discharge on 12/24/13. He was listed by the PNMT as referred on that date, though the PNMT meeting minutes indicated that the referral was on 12/9/13. The action step documented at that time was to complete the PNMT assessment by 1/8/14. His assessment was completed on 1/23/14, within an acceptable 45 days, due to the second hospitalization.	

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		As described above there were significant inconsistencies related to the PNMTs response to PNM-related events and to referrals from the IDTs. Individual #117 was an example of the PNMT choosing to hold firmly to the referral criteria rather than evaluate the circumstances related to her PNM needs. That is, they did not demonstrate a prompt sense of urgency in their response. Record review indicated the following: • An ISPA held on 12/6/13 reported continued coughing during meals. The IDT SLP and OT appeared to be reviewing her Dining Plan and making adjustments to it to address this. • She was diagnosed with bibasilar pneumonia on 2/11/14, later identified by the Medical Review Committee to be aspiration pneumonia on 3/26/14. • On 3/27/14, the SLP reported that she had been waiting for results from a MBS thought to be completed at Scott and White in February 2014, but had determined that this had not been conducted. There was no discussion documented as to when or how this would be obtained. • There was an ISPA for a post-hospitalization related to pneumonia on 4/11/14. Allegedly, this was related to a MBS study conducted on 4/4/14. At that time, it was reported that her last hospitalization had been in 2012 and she was treated for aspiration pneumonia in March (date and year not specified, but presumed to be 2014). A PNMT referral was to be made due to two incidences of aspiration pneumonia in two months. The PNMT RN was present at that meeting. There was no IDT review of this prior event in an ISPA at that time. • Per an ISPA held on 4/14/14, the SLP had recommended a diet texture change from ground to pureed on 3/4/14. It was not clear why the meeting to discuss this was not held until over a month later. It was documented that another MBS was to be requested. • On 4/25/14, the team met to discuss a PNMT referral. It was reported that she did not meet the criteria secondary to not having two episodes of aspiration pneumonia in the last year. It was stated that she would not be assessed by the PNMT. The PNMT RN and PT were present. • The PNMT documented, from 3/6/14 through 5/1/14, that she had not had two episodes, though someone needed to confirm this. The first referral had been discontinued and the team denied the second referral as of 4/24/14. • Again on 5/2/14, an ISPA was held to discuss referral to the PNMT. Again it was stated that she did not meet the criteria. The QIDP documented that she had experienced two, but the dates were not listed. Per this meeting "it was discussed that she did not qualify, due to having only one episode of aspiration pneumonia. However, there have been two episodes and PNMT will not be providing services." In the PNMT meeting minutes on 5/1/14, however, that team indicated that they had confirmed two episodes and she was to be assessed. • The PNMT PT was to contact the IDT to request another ISPA related to this	

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		referral by 5/9/14 and the assessment was listed as due on 5/10/14. • There was a PNMT assessment in her individual record. It documented that the assessment was conducted from 4/11/14 through 5/9/14, though per documentation submitted, the team had denied this referral. This was not consistent with other documentation by the PNMT and the IDT. The IDT must consistently conduct ISPA meetings related to PNM events in a timely manner based on accurate data. All team members have a responsibility to contribute to this. The PNMT should not quibble over the criteria, wasting valuable time, which could be spent in the support for individuals with significant PNM needs. The monitoring team has expressed concern over this particular criterion, in that waiting for two aspiration events before taking action is not a responsible approach. In some cases, it was further noted that the re-referral criteria for individuals is that they must again experience two aspiration pneumonias before a referral was again deemed necessary. This was the case for Individual #117. There were two individuals listed who had received enteral tube placements since the previous review (Individual #230, Individual #38). • 1 of 2 (50%) of individuals who received a feeding tube since the last review had been referred to the PNMT prior to the placement of the tube (Individual #80). Tube placement was the recommendation of the PNMT upon completion of this assessment. • 1 of 2 (50%) individuals who received a feeding tube placement since the last review had been referred to the PNMT after the tube placement (Individual #629). This tube placement was not planned and was subsequent to a fall from his bike and resultant hospitalization. There was an IPN noting that he presented with left lower lobe pneumonia as early as 12/16/13. His history suggested that he was a smoker, had a diagnosis of dysphagia at the time of admission, and had experienced coughing at meals and chronic aspiration. It was not clear why a referral was not made to the PNMT upon his admission for a review of his case. <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 as completed in the last six months included the following: Individual #524 (4/22/14), Individual #293 (3/6/14), Individual #395 (1/15/14), Individual #80 (12/2/13), Individual #888 (11/18/13), Individual #577 (1/23/14), Individual #43 (11/24/13, no signature date), Individual #117 (5/23/14), Individual #441 (11/18/13), and Individual #629 (5/9/14/14). Four	

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		reports were completed during the period of the previous review and, as such, were not included (Individual #888, Individual #43, Individual #441, and Individual #80). Two additional assessments scheduled to be completed during the week following this onsite review were requested to be sent electronically. These, however, were not completed in time for review by the monitoring team. In the case of Individual #43, he was referred again to the PNMT on 4/16/14 for a Stage III wound. As of 6/9/14, his assessment was incomplete. By report, he was admitted to the hospital on that date, and the team indicated that "per Protocol," they had another 30 days to complete his assessment. It was not clear what protocol they were referring to. There was no documentation or rationale documented to justify why this assessment had not been completed. It was not acceptable that nearly two months later it was still incomplete, regardless of this most recent hospitalization. Individual #297 was referred on 5/13/14 for significant weight loss. By report, she had been admitted to the hospital on 6/12/14 and the PNMT had not completed her assessment. They planned to also give themselves an additional 30 days to complete this assessment. It should have been completed at the time of this hospitalization and further changes to her plan and interventions at the time of discharge would merely be an aspect of ongoing PNMT supports and services until such time she met established discharge criteria from the team. • 1 of 6 PNMT assessments (20%) was initiated at a minimum within five working days of the referral, per the dates in the assessment, meeting minutes, and IPN documentation. This was an improvement from 0% in the previous review. • 0 of 5 PNMT assessments (0%) were completed in 30 days or less of the date of the original referral, per the core team member signature dates. It should be noted that physician review was generally also not completed until later, so these should not be considered a completed evaluation until that review was conducted and at such time as all core team members had signed. Based on review of these assessments, the following elements were addressed: • Date of referral by the IDT or self-referral (6 of 6, 100%). However, documentation of referrals was noted in PNMT meeting minutes and ISPAs that did not consistently correspond with the referral dates listed in the assessments. The referral source was not identified with one exception (Individual #293). • Date the assessment was initiated (4 of 6, 67%). • Evidence of review and analysis of the individual's medical history (3 of 6, 50%). In all but one case (Individual #629), a list of medical history events were listed with dates of occurrence. Analysis was limited in the two cases in which this was noted (Individual #395, and Individual #577), though this was somewhat improved for Individual #629.	

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		• Identification of the individual's current risk rating(s), including the current rationale (6 of 6, 100%). It was of concern that in some cases, the risk ratings were dated significantly prior to the events that generated a referral. Some examples included: o Individual #577: His risk ratings were dated 8/22/13, and did not appear to have been reviewed/revised in light of his recent hospitalizations due to changes in status in December 2013. o Individual #395: His risk ratings were dated as reviewed and revised on 9/5/13, though he had experienced two occurrences of pneumonia in October 2013. o Individual #117: Her most recent IRRF was dated 11/6/13, yet the team had met several times related to two incidences of aspiration pneumonia in February 2014 and April 2014. • Recommended risk ratings based on the PNMT's assessment and analysis of relevant data (2 of 6, 33%) (Individual #395 and Individual #577). It was generally stated that the PNMT agreed or did not agree with the most current risk assessment, but the rationale for this was not stated. • Discussion of the impact of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition (0 of 5, 0%). For example, a suction toothbrush was provided to Individual #629 and it was reported that he refused to use it, and that he and his staff had not been trained to use it. There were no objective data related to any of this in the assessment sections of the report. There was no discussion of his behavior challenges and the impact on the provision of PNM services. This will be a very key element in the success of the prevention of further aspiration pneumonia for Individual #629 and should have been a key element of the PNMT's assessment. • Assessment of current physical status (5 of 5, 100%). This was consistent with the previous review. • Information about the individual's current respiratory status based on a physical assessment (3 of 6, 67%). In some cases this was done in relation to a HOBE assessment, though it was not always clear that it was the PNMT that conducted these. In the case of Individual #117, respiratory status from the IDT RNs post-hospitalization was reported, though this was not repeated over the one month period by the PNMT RN. • Assessment of musculoskeletal status (0 of 6, 0%). The PNMT did not conduct a comprehensive physical assessment, but rather cut and pasted information from assessments and IRRFs completed prior to the events that warranted a referral to the team. Thus, this did not reflect the individual's current status. • Evaluation of skin integrity (2 of 6, 33%). In the case of Individual #524, the PNMT recommended that nursing conduct skin assessments three times a day	

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		documented on a specialized skin assessment form and IPNs, as well as, inservice training for DSPs related to skin checks and reporting in the observation notes. There was no documented evidence that the PNMT had conducted skin assessments, provided inservice training, or worked with the IDT to develop a special form, throughout the assessment period. • Evaluation of posture and alignment in bed, wheelchair, or alternate positioning, or indicated that the individual was independent with mobility and repositioning (5 of 5, 100%). HOBE was recommended for Individual #293, but there was no evidence that this was completed by the PNMT during the assessment period. • Positioning that may impact PNM status including during bathing, medication administration, and oral hygiene based on observations of these activities (2 of 6, 33%). This was noted for Individual #293 for medication administration and oral hygiene, though these were reported in the analysis section rather than in the current assessment sections of the report. Monitoring was conducted for Individual #524 for oral hygiene. It was reported that the techniques were correct, but that toothpaste and gloves were not available in the bathroom. • Evaluation of motor skills (0 of 5, 0%). • List of medications with purpose and potential side effects listed (6 of 6, 100%). This did not address allergies, drug/drug or drug/nutrient interactions and/or actual side effects. • Evidence of review/analysis of medication history over the last year and current medications, such as dosages and side effects (0 of 6, 100%). • Evidence of review/analysis of lab work (1 of 6, 17%), for Individual #117. This was reported only when portions of previous assessments completed by the IDT were inserted into the PNMT evaluation. There was generally no reference to more current lab values. For example in the case of Individual #524, there was a goal established by the dietitian to improve Albumin levels (3.0 on 11/5/13) over the next six months, yet there was no evidence that this had been reviewed at the time of the PNMT evaluation. This would be a significant value to ensure appropriate nutrition for healing post-tibia fracture. Similarly low Albumin/Pre-Albumin levels were noted on 9/17/13 and 10/1/13 for Individual #395. On 10/15/13, repeat blood work in 30 days was recommended by the dietitian. There was no evidence that the PNMT reviewed these findings. • Identified residual thresholds, if enterally nourished (1 of 3, 33%). Though the residual log was reviewed by the PNMT for Individual #395, this was noted on only two occasions after the referral was received (11/26 and 11/28/13). Historically, the residuals were minimal and the team stated that they felt he was tolerating feedings with minimal residuals. There was no evidence of further follow-up through the time of the assessment process on 1/10/14. • Tableside oral motor/swallowing assessment, including, but not limited to,	

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		mealtime observation and/or observation of enteral nutrition (2 of 6, 33%). • Evidence of observation of the individual's supports at the home and/or day/work programs (6 of 6, 100%). This was consistent with the previous review. • Nutritional assessment was minimal (Individual #629) to non-existent (Individual #577). In some cases, information from a previous assessment was cut and pasted into the PNMT assessment with no update as to current status (Individual #524). The dietitian was a core team member and should be expected to participate throughout the entire process. If there are no nutritional concerns, this should be clearly stated based on a full nutritional assessment and analysis. • Evaluation of all current assistive equipment (0 of 6, 0%). These were generally listed, but the effectiveness was not consistently reviewed and documented. For example, a suction toothbrush was provided to Individual #629, but there was no evidence that this had been observed for efficacy and compliance with implementation. It was reported that he refused to use it, and that he and his staff had not been trained to use it. Regarding training, they should have either provided it themselves or facilitated it, rather than reporting this problem and waiting until the end of the assessment process to make a recommendation. • Evidence that the PNMT conducted hands-on assessment (4 of 6, 67%), though this was limited. In one case, the PNMT conducted an assessment over the course of two months for Individual #293, indicating that positioning was key to the prevention of aspiration and reducing GERD. They recommended that the IDT therapists conduct a HOBE assessment to determine the appropriate positioning for him, rather than doing it themselves or in collaboration with the IDT during the two month assessment period. As a result these findings were not available for implementation in a timely manner. • Identified the potential causes of the individual's physical and nutritional management problems (6 of 6, 100%). In many cases, objective data were reported in the analysis rather than using the data to formulate an analysis of the collective findings. • Identified physical and nutritional interventions and supports that were clearly linked to the individual's identified problems (5 of 5, 100%). Analysis and rationale for the recommendations were less consistent. This was often not addressed in the analysis; recommendations were listed without a clear justification in the analysis section. In some cases, recommendations were listed in the analysis section. • Recommendations for measurable skill acquisition programs, as appropriate, (1 of 6, 17%, Individual #629). • Evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP) was not clear based	

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		on review of the assessments. The PNMP was reviewed as current at the time of the referral. In most cases, changes appeared to be merely recommended for IDT implementation rather than more timely implementation. • Recommendations for monitoring, tracking, or follow-up by the PNMT (4 of 6, 67%). These were generic statement that the PNMT would monitor efficacy of the PNMP, for example, until the individual met criteria for discharge from the team. Specific clinical indicators to be monitored by the PNMT to evaluate efficacy were not outlined. • Discussion as to whether existing supports were effective or appropriate (6 of 6, 100%). Monitoring data and effectiveness data previously gathered by the IDT, including PNMP monitoring and trigger data sheets was reported. Findings related to compliance were reported more consistently than effectiveness. Discussion and analysis were limited. • Establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status (0 of 5, 100%). Some were generally established as triggers in the original risk review by the IDT, but these were not specifically addressed by the PNMT. This is not the same as criteria for discharge. • Measurable outcomes related to baseline clinical indicators, including, but not limited to when nursing staff should contact the PNMT (0 of 5, 0%). The outcomes listed were limited to PNMT discharge criteria. In most cases, the discharge criteria were limited to no further occurrence of the issue that triggered the initial referral, such as, "no aspiration for three months" or "four months without a new fracture" rather than more discrete outcomes that reflect improved health status, stabilization, specific monitoring findings, and/or completion of specific action steps. • Signatures of all core team members (or alternate) with dates (4 of 6, 67%). In each case, there were one or more core team members that did not sign the assessment report. Specific Concerns: • As discussed during the PNMT meeting, 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. These should be integrated into the IHCPs and IRRFs. Key clinical indicators should be identified that alert the IDT that the individual may need an increase in intervention or monitoring. These may be as basic as vital signs or meal refusals, and should be individualized. These will not likely be the same objectives for re-assessment or discharge from the PNMT. • The assessments appeared to have improved in some aspects, but were widely	

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		inconsistent in content and format. It is again recommended that the team establish guiding questions to ensure that the content for all sections is consistent. The team should consider limiting the reporting of data to the content areas, prior to the analysis section. New data should not be reported there, but rather all data should be analyzed collectively. The analysis of findings should analyze pertinent data, identify the basic underlying causes that resulted in referral, and clearly formulate the rationale for recommendations, actions, and supports required. These should be clearly linked to an aspect of the analysis. • The nutritional assessments were weak or not existent. It is critical that this be adequately addressed. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs/ISPAs</u> There were six assessments submitted as completed by the PNMT since the previous review. Individual records for these individuals were requested and submitted with the exception of Individual #293. Plans contained in the individual records resulting from PNMT recommendations included the following components: • In 0 of 6 (0%) individual plans reviewed, identified PNM needs as presented in the PNMT assessment were addressed/integrated in the ISP/ISPA, IRRFs, and IHCPs. • For 0 of 6 (0%) individuals for whom HOBE assessments were conducted, the recommendations were integrated into the individual plans. In some cases, this was noted in one, but not both the IHCP and IRRF (Individual #117). The IHCP for Individual #629 contained an addendum, rather than a change in status IHCP. Though this reflected the recommended 30 degree elevation, the IRRF (1/16/14) continued to reflect that he ate orally and that head of bed elevation was at 25 degrees. A HOBE was not conducted for Individual #524, though this should have been. A HOBE was recommended for Individual #577 and Individual #395, but not conducted during the one and two month periods of their PNMT assessments. This was conducted on 1/17/14. A consult report on that date was noted in the Habilitation Therapy section. The findings indicated that he should be at 35 degrees of head elevation to decrease the risk of aspiration. There was no reference to this in the IHCP or DSP instructions, though the IRRF indicated 30 degrees elevation. • For 0 of 6 (0%) individuals, there were appropriate, functional, and measurable objectives outlined to allow the PNMT to measure the individual's progress and efficacy of the IHCP and PNMP. There was no clearly correlation between these and the PNMT assessments. • In 0 of 6 (0%) individual plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. Completion was listed as ongoing or was the date also of implementation.	

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		• In 0 of 6 (0%) individual plans reviewed, the specific clinical indicators of health status to be monitored were included. This was typically related to routine nursing care. Individualized indicators were not well outlined in the PNMT assessments. • 6 of 6 (0%) individual plans defined triggers. General triggers were listed, but were individualized. • 6 of 6 (100%) individual plans identified the frequency of monitoring. This was typically related to nursing only. The frequency of monitoring by Habilitation Therapies and the PNMT were not generally outlined. There was no evidence that IRRFs and IHCPs were consistently revised based on changes in status for individuals who experienced significant health events that warranted a referral to the PNMT. The revised documents should provide adequate detail for implementation of supports and services collaboratively by the IDT and the PNMT. Only in the case of Individual #629 was the IHCP updated to reflect his more current status, but this was done prior to completion of the PNMT assessment and there was no evidence of subsequent review. A Change of Status IRRF should be conducted to reflect that the IDT and PNMT reviewed the individual's status and support needs. DSP instructions contained in Individual #524's record were dated 2/10/14, a month prior to her injury with fracture. Recommendations identified in the PNMT assessment dated 1/15/14, were not integrated into the IHCP associated with his ISP on 1/30/14. The most current IRRF for Individual #577 was dated 8/22/13, though his PNMT assessment was completed on 1/13/14. Changes to the risk ratings were recommended by the PNMT. There was no evidence of an IHCP in his individual record. In the case of Individual #117, a single page (Change of Status Integrated Risk Rating Form) dated 4/11/14 was inserted with the IRRF dated 11/6/13 related to a change in her risk for respiratory compromise. There was a significant risk that the single page would become separated from the original IRRF and would, thus, be deemed inaccurate. There was no evidence that the IHCP (11/6/13) was updated. It continued to list the use of the Frasier Protocol, though this had been discontinued. Head of bed elevation was not included, nor was the requirement for suction tooth brushing. The ISPs did not consistently reflect PNMT assessment in the last year. For example, Individual #395 was assessed by the PNMT over a two month period based on a referral due to two possible episodes of aspiration pneumonia in one year. The description of the Dining Plan documented in the ISP stated that his current Dining Plan continued to adequately meet his needs to mitigate risks of aspiration and choking. It further stated that there had been no incidences of choking or aspiration during the last year, though the several paragraphs above that it was reported that he had possible aspiration pneumonia	

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		in January, February, May, and October 2013. PNMT Follow-up and Problem Resolution Each of the recommendations identified in the PNMT assessment should be clearly and consistently tracked through to completion with timely implementation. The PNMT may want to consider the development of a recommendation log in order to track its own timeliness. The recommendations in the assessments were not tracked in the meeting minutes, but rather more logistical action such as to complete the assessment, PNMT follow-up (with no specifics), notify MD of an issue, etc. There were approximately 270 actions listed with 85% of those having an identified due date. Only 28% of these had a documented date of completion. Only 17% were listed as completed on or before the established due date. The following metrics were based on the plans co-developed with the IDT. These were not consistently evident as described above and could not be adequately assessed. • For --% of individuals, implementation of individual action plans was within 14 days of development of the plan or sooner as needed for health or safety. • For --% of individuals, action plan steps had been generally completed within established timeframes. This could not be determined based on the IHCPs submitted because the completion dates were not consistently documented. Intervals of PNMT review were not clearly stated in the assessments. The dates of subsequent reviews were also not identified in the meeting minutes. There was a PNMT Follow-up Tracker submitted that outlined dates of referral, due dates for assessments, and completion dates for 26 individuals. Six assessments did not appear to have been completed and 10 were documented as completed in a timely manner. Follow-up dates were listed in some cases, but it was not clear if these were completed on an established interval. Each individual listed was also identified as currently discharged from PNMT services, though none of the six individuals with completed assessments submitted for review as described above, were included in this log. IPNs were consistently entered by the PNMT, but were often generic in nature rather than reflecting specific actions taken, outcomes, and dates of completion and follow-up consistent with the meeting minutes. All of this needed to be better-integrated into the ISP process. Individuals Discharged from the PNMT Discharge was reported for the following individuals: Individual #216, Individual #314, Individual #310, Individual #80, Individual #577, and Individual #395. Assessments, ISPs, ISPAs, IRRFs, IHCPs, and discharge documentation were requested and submitted. • A discharge summary provided objective clinical data to justify the discharge and to identify any new or outstanding recommendations for integration into the IHCP for 3 of 6 individuals (50%). These were not technically discharge	

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		summaries completed by the PNMT. In two cases, there was an IPN referencing an ISPA meeting held to discuss the details of discharge with the IDT. The ISPA documentation identified detailed information related to justification for discharge in each of these three cases. In two other cases, there was a brief IPN written by the PNMT, and the ISPA did not provide adequate detail. In the case of Individual #310, there was no IPN written by the PNMT and the ISPA was lacking in details related to discharge rationale. • There was evidence of ISPA/ISP documentation and/or action plan for discharge of 6 of 6 (100%) individuals, though these did not consistently include clinical indicators to track health status and criteria for referral back to the PNMT. 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 should be an equal 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 did not consistently demonstrate that they understood this responsibility. The facility self-rated this provision in noncompliance, and the monitoring team concurred based on the numerous concerns listed 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. Ensure that the PNMT assessments address the essential elements outlined above and that the information is presented clearly and succinctly. 2. Ensure that clinical indicators are well outlined to reflect improvement in health status relative to the efficacy of supports and services provided. 3. Review the current discharge criteria to drill these down to more discreet measures to ensure that individuals are re-referred to the team in a more timely manner, rather than waiting for the same level of criteria (negative health outcomes) to re-occur before actions were taken. 4. Ensure that all recommendations and actions identified in the PNMT assessments are adequately documented in the ISPs, ISPAs, IRRFs, and IHCPs. 5. Ensure that assessment, discharge and other key elements of support from PNMT service are reflected in a discharge summary written by the PNMT and captured in the ISPA. 6. Consider a recommendation log to readily track completion of action steps or attempt to more accurately and consistently capture these in the meeting minutes for translation to the discharge summary when indicated.	

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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.	Identification of Individuals Requiring a PNMP As described above, approximately 97% of the individuals with identified PNM needs were provided a PNMP at MSSLC. 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 determined which team members should attend the annual ISP meeting. Teams were also required to provide clear justification if they decided that therapists involved in the individual's care and treatment did not need to attend. Review of the PNMP and Dining Plans was required by the IDT at least annually during the ISP meeting. Likewise, all other supports and services provided through OT/PT/speech and the PNMT should be reviewed by the IDT and well integrated into the ISP and/or ISPA. This required that key team members be present, including the PNMT, OT, PT, and/or SLP clinicians, as well, as the QIDP, DSP, RNCM, behavioral health specialist, RD, and physician, among others. The current system also required that the IDT designate which team members were required to attend the annual ISP during the pre-ISP meeting. For individuals in Sample O.1, ISP attendance and pre-ISP documentation related to required attendance were reviewed. Review of the ISPs submitted was as follows: • 100% (16 of 16) of the ISPs submitted were current within the last 12 months. • 94% (15 of 16) of the current ISPs had attached signature sheets. Completed pre-ISP required attendance sheets were not submitted for five individuals Individual #43, Individual #432, Individual #503, Individual #524, and Individual #441. A signature sheet for Individual #197 was not submitted, so was scored as a zero below. • For 0 of 16 individuals (0%), all of the appropriate disciplines were present at the ISP meeting to approve and integrate the PNMP into the ISP. Individual #888 did not require a PNMP, but this was documented in the ISP with rationale. Most consistently, the DSPs, QIDPs, and RNCMs were present at each meeting. A dietitian was present for only 4 of 16 meetings and a PCP was present for only 1 of 16 meetings. It was noted that one or more Habilitation Therapies representatives were present at each meeting. Typically, this would be an acceptable approach due to consistent communication and collaboration among these therapists. This was not clearly in place at MSSLC, however. For example, in the case of Individual #557, only the OT and SLP representatives were present. There was inadequate review of the PNMP and equipment listed in the plan had not been in use for over a year per the DSP present. This should have been identified as an issue during compliance and effectiveness monitoring, as well as,	Noncompliance

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		during the annual OT/PT assessment. The OT present could not speak to this concern and indicated that she would have to discuss this with the PT. • For 7 of 10 individuals for whom pre-ISP required attendance sheets were submitted (70%), the designated team members were present for the ISP meeting per the sign-in sheet. In most of these cases, however, the appropriate team members required to review and approve the PNMP were not designated to attend. Regarding PNMP review: • 15 of 15 PNMPs (100%) indicated some level of review by the individual's IDT in the annual ISP meeting. The reviews documented in the ISPs varied significantly in specificity and thoroughness and not all clearly identified what changes were required and efficacy of the plan. None specified the frequency of monitoring needed, but rather stated merely that monitoring would be ongoing. • For 7 of 13 (54%) individuals in Sample 0.1 for whom the IDT identified changes needed to be made to the PNMP in the interim of the annual ISP, revisions based on the IDT discussion were integrated into the PNMP (exceptions were Individual #597, Individual #376, Individual #197, Individual #80, Individual #503, and Individual #524). These did not include a clear rationale, plan, or timeline for implementation. Though clear timeframes for completion were not stated, they were usually made that day or within 48 hours. In the case of Individual #197, an ISPA held on 5/19/14, indicated that the PNMT had recommended HOBE to be 35 to 45 degrees when on the right side. There was no IPN documentation related to this and his most current PNMP dated 5/15/14 indicated that he should be at 30 degrees at all times. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample 0.1: • PNMPs for 15 of 15 individuals (100%) were current within the last 12 months. This was consistent with the previous review. • PNMPs for 15 of 15 individuals (100%) included a list of PNM risk levels and individual triggers. This was consistent with the previous review. • In 15 of 15 PNMPs (100%), there were large and clear photographs with instructions, or were identified as generally independent. This was consistent with the previous review. • 14 of 15 PNMPs (93%) identified the assistive equipment required by the individual with rationale and purpose (exception was Individual #197). This was a decrease from 100% in the previous review. • In 13 of 13 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair. This was	

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		consistent with the previous review. • In 15 of 15 PNMPs (100%), positioning was adequately described per the individuals' assessments or the individual was described as independent. This was consistent with the previous review. • In 15 of 15 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. This was consistent with the previous review. • In 15 of 15 PNMPs (100%), bathing instructions were provided. This was consistent with the previous review. • In 15 of 15 (100%) PNMPs, toileting-related instructions were provided, including check and change. This was consistent with the previous review. • In 14 of 15 (93%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning (the exception was Individual #197). Each of the others was described as independent. This was a decrease from 100% in the previous review. • In 15 of 15 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was consistent with the previous review. • 15 of 15 individuals' (100%) Dining Plans were current within the last 12 months. This was consistent with the previous review. • 4 of 15 individuals had feeding tubes with no oral intake. 4 of 4 PNMPs/dining plans (100%) specifically stated that the individual was to receive nothing by mouth, when indicated. This was consistent with the previous review. • In 15 of 15 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 consistent with the previous review. • In 11 of 11 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 consistent with the previous review. • In 10 of 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. This was consistent with the previous review. • In 14 of 15 PNMPs (93%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. The exception was Individual #117. This was a decrease from 100%	

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		in the previous review. • In 15 of 15 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. This was consistent with the previous review. • 3 of 15 PNMPs (20%) included information related to communication (how individual communicated and how staff should communicate with individual). The others merely referenced the Communication Dictionary for interpretation of what the individual was communicating. The PNMP did not provide specific strategies for the staff as to how they should communicate with the individual. This was a decrease from 100% in the previous review. <u>Change in Status Update for PNMPs Conducted by the IDT/PNMT</u> There were at least 12 individuals with a documented change in status included in Sample O.1 and an ISPA meeting was held to document that the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. • For individuals for whom the PNMP was revised, there was supporting documentation that 100% of the revised PNMPs had been implemented. The changes were made, in most cases, that day or within 48 hours. The facility findings indicated that they continued to be in substantial compliance in O.3. There had been some reduced levels of performance and the monitoring team did not concur. The ISPA process was well documented and the PNMPs generally contained the essential elements. The ISPs were well attended by Habilitation Therapists, but attendance by other team members essential to review and approval of the PNMP were not consistent. The PNMP appeared to be consistently reviewed by the IDTs, however. Changes in status were accompanied by review of the PNMP in some cases, though there were a number of omissions 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. The facility should review the system of the determination of who should attend the ISP during the pre-ISP. This was not consistently documented and many did not appear to consider a need to review the PNMP and other aspects of the individual's annual plans in these determinations. Attendance should then be consistent with these determinations. 2. Ensure better communication across Habilitation Therapy professionals for improved representation at the ISPs/ISPAs. 3. All designated changes to the PNMP identified in the ISP/ISPA must be made and implemented within 24 to 48 hours for critical changes and no more than 30 days for changes that were non-critical to health and safety.	

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O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>Monitoring Team's Observation of Staff Implementation of PNMPs</u> Dining Plans were generally readily available in the dining areas and PNMPs were included in the individual notebook. General practice guidelines (foundational training) were taught in NEO and in individual-specific training by the therapists, PNMPCs, and residential staff. Based on observations conducted by the monitoring team: • 90% of dining plans were implemented as written for approximately 50 individuals observed (errors noted for Individual #332 and Individual #235). • 92% of PNMPs for approximately 40 individuals related to positioning and mobility were implemented as written, or alignment and support were consistent with generally accepted standards. Based on additional observations: • 67% of six transfer plans/repositioning were implemented appropriately or consistent with generally accepted standards. In both cases where problems were noted, staff had to be prompted to re-position the individual and then also required coaching in how to conduct these. The individuals were not in any danger, but these staff required training and monitoring. • (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. • (NA) individuals' oral hygiene plans were implemented appropriately or consistent with the PNMP. No oral hygiene was observed during this review, so this metric was not rated. • In 100% of observation of medication administration for all individuals by the monitoring team, the SSLC nurse followed procedures in the PNMP. Other observations were made by the RN member of the monitoring team. See section M-Nursing for findings. The facility implemented Mealtime Coordinator (MTC) training consistent with the statewide plan. A Mealtime Coordinator was seen in most of the homes, but their role was not always evident. A trainer was present in at least three of the meals. In one case, this staff did an exemplary job of coaching and supporting staff. In the other case, the trainer was assisting one individual with the meal, and interaction with other staff was not observed. Standardization of this process is essential to ensure adequate competency of these key staff. Unit directors need to continue to be intimately involved in implementation and oversight of the program in all homes. 5 of 6 staff (83%) staff were able to answer questions related to risks and the purpose of strategies outlined in the PNMP or Dining Plan. These questions pertained to rationale for assistive equipment, areas of risk and triggers, rationale for food textures and liquid	Substantial Compliance

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		consistencies, transfers, and positioning. 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 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 monitoring team determined that the facility was in substantial compliance with this provision. The elements that fell below 80% were small samples and likely skewed these findings. The facility should ensure that the Mealtime Coordinator position is fully implemented across all homes for all meals. A focus on transfers and re-positioning should be considered during the next six months. Observations related to oral hygiene will be conducted during the next review.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>NEO Orientation</u> • MSSLC had a system of comprehensive competency-based training regarding PNM services. Training provided skill performance check-offs that included a demonstration component to assess staff, but without adequate opportunities for active participation and practice of the skills necessary for appropriate implementation of PNMPs. Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. Based on the schedule submitted, class time included approximately 11 hours to address lifting, mealtimes, and other aspects of Physical Nutritional Management. The topics, based on review of the curriculum materials, were comprehensive. There was a presentation of instructional content and foundational skills, with modeling by the trainers, to new employees. New employees were given limited, if any, time to practice new skills, but were required to take a combination of written tests and checked off on specific skills. Return demonstration was required for each skill. Employees were expected to pass all essential elements of the core competencies. The legitimacy of competency testing was likely limited given the timeframes permitted.	Substantial Compliance

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		Staff received on-the-job training and mentoring related to the PNMPs and Dining Plans on the assigned home, as well as on individual-specific (non-foundational skills) competencies, with the PNMPCs. Correct answers to a core list of questions were required of the new employees to pass this part of NEO training. Shadowing was then conducted prior to new employees being permitted to work independently on their assigned homes. They were not assigned a caseload, but were allowed to assist existing staff in the implementation of foundational skills in that home. By report, staff were not permitted to float to another home for the first month of their employment. • 126 of 126 staff (100%) completed NEO core PNM training (i.e., foundational skills) based on the participation reports. It could not be determined from the documents submitted whether this included the lifting portion of NEO. • There was a system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators. A sample packet of information to demonstrate the extent of the check-offs required for validation of staff who conducted training and check-offs was submitted. A two-hour refresher training was provided in the area of lifting/transfers. This also included a number of the competency check-offs used in the NEO training described above. Again, the training contained good content, though the time available for instruction was very limited, with no opportunity for practice, but rather only check-offs. • --% of staff required to take the Annual Refresher class related to PNM successfully passed the competency check-offs. This metric could not be applied because it could not be determined from the documents submitted how many existing staff had taken this class in the last six months. o 126 staff were listed as taking Physical Nutritional Management and 643 were listed as taking Lifting People. There were 114 listed as taking Alternate Means of Communication. Each of these was identified as an Active Employee Course Participation Report, however, MSSLC did not provide refresher training related to communication. As such, it was not clear whether the records submitted related to NEO or refresher training and how many existing staff were required to take each refresher course and how many had successfully completed each. • There was a system to establish and maintain competency for staff who provided the training. A sample packet of information to demonstrate the extent of the check-offs required for validation of staff who conducted training and check-offs. <u>Individual-Specific Competency-Based Training</u> Non-foundational training was provided by Habilitation Therapy staff in the case that a required element of the individual's plan was not included as a core competency in the NEO/refresher training curriculum. This type of training required competency check-offs	

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		in order that staff could implement that element. By report, there was a very limited number of individuals identified with non-foundational components related to their PNMPs. The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. • Per the system in place, 100% of the staff assigned to individuals were trained related to individualized PNMP strategies prior to the provision of services. • Per the system, 100% of the staff assigned to individuals had completed competency check-offs in all specialized components of their communication plans (i.e., non-foundational skills) prior to the provision of services. • The facility had a process to validate that staff responsible for training other staff were competent to assess other staff's competency. The facility self-rated noncompliance with this provision, however, the monitoring team determined that substantial compliance was obtained based on the findings above. Still: 1. Clarification of the staff who had successfully completed all competency-based training was needed. 2. As identified by the facility in the self-assessment, they are encouraged to move forward with the inter-rater reliability aspect for Mealtime Coordinators and for compliance monitoring.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>Facility's System for Monitoring of Staff Competency with PNMPs</u> MSSLC implemented a system for compliance monitoring of the implementation of PNMPs conducted by the Habilitation Therapy professional staff, though this was completed by therapists only at the time of this review in conjunction with effectiveness monitoring. This was done by the PNMPCs at one time, but was discontinued over a year ago and had not yet resumed. A plan was in place to resume this process in the near future. This monitoring included staff compliance for implementation of PNMPs/Dining Plans and the condition and availability of adaptive equipment. There was no standardized system to ensure routine and consistent monitoring of staff related to implementation based on individuals and their established risk levels. • The tools included adequate indicators to determine whether staff demonstrated competency to safely and appropriately implement the PNMP, though these were generic in nature and it was not always clear what was monitored. For example, in the case of Individual #524, she was monitored for positioning on 5/8/14. It was not clear if positioning in bed, a chair, and/or wheelchair was observed on that date. This was noted on a number of the forms. During the course of the month, monitoring was conducted for positioning and lifting/transfers, but there	Noncompliance

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		was no evidence that other aspects of the PNMP were monitored. • There were sufficient instructional guidelines for those using the forms to monitor. • It was not clear what training had been provided to therapy staff relative to the process of monitoring the elements of the PNMP. It did not appear that all areas of the PNMP had been consistently monitored based on the forms submitted (three months of monitoring for each individual in Sample P.1 was requested). There were no recommendations as to the frequency of compliance monitoring required for the individuals in the Sample O.1 in their annual assessments. Additionally, there were no guidelines provided to therapists to guide the frequency of PNMP/Dining Plan monitoring in a systematic and consistent manner. This element was self-rated to be in noncompliance. There was no well-established or consistently implemented system of compliance and effectiveness monitoring 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. Establish benchmarks, a tracking system and schedule for compliance monitoring. It appeared that some monitoring was done, but there was no clear method to determine if all areas of the PNMP were addressed at an established frequency. 2. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>Monitoring by the IDT and/or PNMT to Assess individual Progress and Plan Effectiveness</u> There was also a system established for effectiveness monitoring by the therapists, though this was not clear based on the documentation submitted. The frequency was not reported as a recommendation in the annual assessments or the PNMT evaluations. Effectiveness monitoring guidelines should indicate that this should occur as follows: • Monitor upon initiating a new plan • Monitor upon modifying a plan • Monitor following identified issues or concerns • Monitor no less than quarterly, unless there was a clear rationale • IHCPs inconsistently contained indicators identified to assess the individual's PNM status. • Based on the sample of individuals selected for O.1, evidence of effectiveness monitoring for each was requested for the last six months. This was provided for 15 of the 16 individuals in Sample O.1 (Individual #888 did not require a PNMP).	Noncompliance

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		The compliance monitoring form included a section that addressed effectiveness monitoring and both were conducted in conjunction by a licensed therapy clinician. Only 12 forms addressed the effectiveness of the Dining Plan. Six addressed Oral Hygiene and only one addressed Bathing. Only four forms addressed Medication Administration. Approximately 24 reviewed effectiveness of positioning plans and 13 forms reviewed lifting and transfers. This was very minimal for 15 individuals over a six month period, when it would be expected that all aspects of the PNMP would be monitored no less than quarterly and in many cases, based on PNM risk levels, on an even more frequent basis. • For 0 of 11 individuals with Aspiration Trigger Sheets (0%), there was evidence that the IDT identified the need for, and developed, individualized triggers. • Trigger sheets for 2 of 11 individuals were generally completed correctly (18%), with very few blanks, though the systems used varied across shifts and individual staff. • Trigger sheets for 11 of 11 individuals were reviewed at least daily by the nurse, though instructions were for review every shift. Though many were reviewed on multiple shifts, there were numerous blanks in the documentation suggesting that a shift nurse had not reviewed the data as instructed in the Trigger Sheet. The monitoring team concurred that the facility was not in compliance with this provision. 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 consistency of effectiveness monitoring as conducted by the therapy clinicians and the PNMT to ensure that the frequency is as recommended and that the guidelines are followed as to this process to address each of the necessary elements. Effectiveness monitoring guidelines should be developed to indicate that this should occur as follows: o Monitor upon initiating a new plan o Monitor upon modifying a plan o Monitor following identified issues or concerns o Monitor no less than quarterly, unless there was a clear rationale 2. Establish benchmarks for tracking of the timely completion of effectiveness monitoring as specifically outlined in the assessments. 3. Ensure use of trigger sheets was consistent with the facility guidelines.	

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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.	Evaluation of Individuals who Received Enteral Nutrition • The facility maintained and updated a list of individuals who were enterally fed. There was a list of individuals that identified 28 individuals who received enteral nutrition. Four of these were gastrostomy-jejunostomy tubes. The type of feeding was requested (bolus, intermittent, continuous), but the type of formula was listed, instead. Thirty-seven were identified as NPO; five received pleasure feedings. Whether the individual was NPO or received some other level of oral intake was not listed. Individual #629 and Individual #80 were listed as having tube placement since the previous review. Nine individuals with enteral nutrition had at least one incidence of aspiration pneumonia in the last six months. Three were listed with poor oral hygiene. A sample of 10 APENs was requested, as completed since the previous review. No APENs were submitted, but rather the current IRRF forms for nine individuals were submitted (Individual #533, Individual #435, Individual #528, Individual #341, Individual #35, Individual #188, Individual #285, Individual #80, and Individual #395). • 0 of 9 individuals (0%) who received enteral nutrition (Sample O. 3) were evaluated at a minimum annually based on the APENs submitted. • 0 of 9 individuals with APENs (0%) had an appropriate evaluation to determine the medical necessity of the tube since the previous review. 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. There was insufficient assessment by the dietitian and, in most cases, the diet order and rate were not reported. The oral motor assessments were significantly improved. • For 1 of 9 individuals (11%), for whom the IRRF were submitted, there was evidence of adequate discussion by the team related to the medical necessity of the team. • --% of 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. No one who received enteral nutrition had been admitted to MSSLC since the previous review. 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 and/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.	Noncompliance

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		• Monitored as outlined in the plan. <u>PNMPs</u> All individuals who received enteral nutrition in the selected sample had been provided a PNMP and Dining Plan that addressed positioning during enteral intake. The monitoring team concurred with MSSLC'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. Establish protocol related to the completion and use of comprehensive assessments by key IDT members, 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:** <u>Documents Reviewed</u>: o MSSLC client list o Admissions list o Staff list o Section P Presentation Book and Self-Assessment o Section P QA Reports o OT/PT Draft Policy o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring templates 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 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 List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months 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 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

	○ OT/PT Assessment Tracking Log ○ Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to MSSLC: Individual #871, Individual #629, Individual #937, Individual #697, and Individual #872. ○ OT/PT Assessments, ISPs, and ISPAs, and other documentation related to OT/PT supports and interventions for the following individuals: Individual #557, Individual #937, Individual #697, Individual #988, Individual #259, Individual #264, Individual #554, Individual #98, Individual #451, Individual #462, Individual #703, Individual #524, Individual #873, Individual #376, and Individual #365. ○ Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #43, Individual #432, Individual #188, Individual #395, Individual #503, Individual #524, Individual #80, Individual #629, Individual #376, Individual #407, Individual #597, Individual #197, Individual #117, Individual #441, Individual #888, and Individual #577. ○ PNMP section in Individual Notebooks for the following: • Individual #43, Individual #432, Individual #188, Individual #395, Individual #503, Individual #524, Individual #80, Individual #629, Individual #376, Individual #407, Individual #597, Individual #197, Individual #117, Individual #441, Individual #888, and Individual #577. ○ Dining Plans for last 12 months, Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #43, Individual #432, Individual #188, Individual #395, Individual #503, Individual #524, Individual #80, Individual #629, Individual #376, Individual #407, Individual #597, Individual #197, Individual #117, Individual #441, Individual #888, and Individual #577. <u>Interviews and Meetings Held</u>: ○ Sandra Opersteny, PT, Habilitation Therapies Director ○ Lisa Finley, COTA ○ Various supervisors and direct support staff <u>Observations Conducted</u>: ○ Living areas ○ Dining rooms ○ Day program areas ○ ISP for Individual #557 ○ Pre-ISP for Individual #497

	Facility Self-Assessment: The self-assessment completed by Sandra Opersteny, PT, Habilitation Therapies Director, and Lisa Finley, COTA, was improved from the last review. Activities listed as conducted were relevant. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of elements were addressed and used to determine compliance. Findings were consistently reported in measurable terms, though inaccuracies and inconsistencies were identified by the monitoring team. Though the self-assessment was created for the monitoring team, this should be a process used by the department to track and determine progress with the elements of the Settlement Agreement and to direct the necessary actions for the department to effectively focus staffing, administrative support, and oversight. 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, in general, continued to demonstrate hard work, though there was limited progress related to the elements of Section P. The department leadership rated itself in noncompliance with P.1 through P.4 and the monitoring team concurred, except that P3 was rated in substantial compliance due to its tie to section O5. 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 the audit system promotes improvements in the content of OT/PT assessments at or near 90%, the standard held by the monitoring team. These audits should be conducted through the review period rather than only for the self-assessment to permit them to identify concerns and implement appropriate corrective actions and review these for effectiveness for improvement. 2. The ACS should address essential findings from the last year, but should not be equivalent to a full comprehensive assessment. This will permit these to be completed in less time and permit more opportunities for direct supports and interventions. The essential elements must be identified with specific guidelines established to ensure that there is improved consistency with these. This will also assist in the audit process for these assessments as well as the Comprehensive Assessments. 3. Rationale in the pre-ISP process for therapist attendance or non-attendance at the ISP needs to be sound and clearly supported. 4. 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. 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 describe termination, with rationale. 6. There should be standardization of documentation of therapy services established. While the clinicians routinely documented treatment interventions, there was no assessment justifying these on a consistent basis. Additionally, there was not an adequate discharge summary to review the course of treatment and provide justification for termination. 7. Establish benchmarks, a tracking system, and schedule for effectiveness monitoring by OTs and PTs.

	It appeared that some monitoring was done, but there was no clear method to determine if all areas of the PNMP were addressed at an established frequency. Effectiveness monitoring of the Dining Plan appeared to occur infrequently. 8. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. 9. Develop procedural guidelines to outline specifics of each of the elements of service provision as outlined in the Settlement Agreement.
	Summary of Monitor's Assessment: There were limited improvements in the provision of OT/PT supports and services. The essential element sections should be carefully reviewed so that content of some elements can be further refined. OT/PT-related supports and services must be better integrated into the ISP. Supports introduced in the interim must be reflected via assessment and also be reflected in an ISPA. The clinicians should continue to be challenged to examine the existing plans to determine if supports are effective, but also least restrictive. A very clear and sound rationale must be delineated, rather than to continue the same supports merely because they were in place for some time. Observations during an ISP and pre-ISP during this onsite review suggested that review of the current supports and careful determination that they continued to be effective was not consistent. There were supports listed for one individual in the PNMP that were not discussed by the therapy representative at the meeting or questioned by any other IDT member. When prompted by the monitoring team, the DSP indicated that these had not been in use during the last year. This was of considerable concern. This review should occur during the annual assessment by the therapists and then via discussion with IDT to confirm that a support should be continued with a sound rationale. This should include all equipment and strategies. Assessments were generally conducted in the therapy room rather than in the natural environments (other than mealtime). This approach to assessment will permit the clinicians to see how the individual functions in his or her environment to identify unique potentials and needs and to better interact with staff to gain insight on the individual. There were improvements in the implementation of PNMPs for health and safety in the Martin unit. Also, there were a number of individuals engaged in direct OT and/or PT services. They must now take the next step to build on this by increasing the functional and meaningful aspect of active treatment and daily engagement throughout the day. This will be accomplished only by beginning to work shoulder to shoulder with staff in the homes and day programs to model interaction for implementation of group activities and SAPs. These should be important to the individuals, a priority in their life to add quality, capitalize on interests, and promote independence in a meaningful way. <u>Samples for Section P:</u> • Sample P.1: 16 individuals for whom an individual record and the most current OT/PT/SLP assessment were submitted. • Sample P.2: 5 individuals newly admitted in the last six months for whom a current assessment or screening was submitted. • Sample P.3: 8 individuals who were provided direct OT and/or PT services per the list submitted.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	<u>Assessments</u> Assessments were appropriately completed per the ISP schedule, change in status, or IDT request. There was a tracking log of assessments completed for ISPs from 12/17/13 through 7/1/14, but it was not possible to track when the most current comprehensive assessment was completed. By report, however, all individuals had received a Comprehensive Assessment. The OTs and PTs completed a Comprehensive Assessment and/or an Assessment of Current Status/Update with the SLPs adding content related to dysphagia. The SLPs also completed a Comprehensive Communication Evaluation and/or an Assessment of Current Status/Update. At the time of this review, some changes had been made to the standard format for these reports (per the state office) and were in use as of 10/1/13. All individuals newly admitted to MSSLC were to be provided a comprehensive OTPT assessment completed within 30 days of admission. All individuals were to be provided a subsequent Comprehensive Assessment in the case of a significant change in status or special IDT request. An Assessment of Current Status was to be provided annually in the interim for individuals who received direct and/or indirect services in years that a Comprehensive Evaluation was not required. Based on this log, timeliness for assessments completed since 12/2/13 was 91%. The following individuals in Samples P.1 had Comprehensive Evaluations current within the last 12 months (dates listed are the signature dates): 1. Individual #577 (8/7/13) 2. Individual #629 (1/14/14) 3. Individual #117 (10/23/13) 4. Individual #407 (7/16/13) 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: 1. Individual #197 (5/1/14) 2. Individual #395 (1/16/14) 3. Individual #432 (1/13/14) 4. Individual #597 (1/2/14) 5. Individual #524 (1/13/14) 6. Individual #80 (1/23/14) 7. Individual #503 (2/11/14, incomplete per copy submitted) 8. Individual #43 (3/4/14)	Noncompliance

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		9. Individual #376 (4/15/14) 10. Individual #188 (3/6/14) None had an associated Comprehensive Evaluation submitted and/or contained in his or her individual record. There was no current OT/PT assessment in the individual records for Individual #888, though this was not required based on his functional status described in a previous Baseline Assessment upon admission. <u>Timeliness of Assessments</u> There were 35 individuals admitted to MSSLC since the last review. A Comprehensive Evaluation was submitted for one of these (Individual #629) and OT/PT screens for four others (Individual #871, Individual #872, Individual #697, and Individual #937). The tracking log listed assessments or screens were completed for each of the 35 individuals with the exception of Individual #688 and Individual #856. • 5 of 5 individuals in Sample P.2 (100%) received an OT/PT assessment or screen within 30 days of admission based on the signature dates of the assessments submitted for review. Based on the assessment log, overall completion of assessments or screens within 30 days of admission was 81% (there were six assessments not listed as completed at the time of this review). • 0 of 2 individuals (0%) identified with therapy needs through a screening, received a comprehensive OT/PT assessment within 30 days of identification. OT services were recommended for Individual #697 and, as such, a comprehensive assessment should have been completed. In the case of Individual #259, it was reported that he had been provided a PNMP for a mouthpiece issued by dental for teeth grinding at night. He was provided a screening rather than an Assessment of Current Status. Any individual who was provided a PNMP should be provided an annual assessment. That said, the monitoring team questions the need for a PNMP for this device. This could be addressed more appropriately in the IHCP. Individual #259 was functional in all areas of ADLs and motor skills and no other OT/PT-related supports were indicated. It was later reported that that the ISP indicated that a PNMP was not required. This should be discussed at the pre-ISP and then the therapist could be assigned only a screening at that time. The screening should then clearly state that, though these needs were identified, a PNMP was not indicated due to his functional level and that a comprehensive or Assessment of Current Status was not indicated. It should further state that this support would be addressed in the ISP and IHCP. The clinicians should ensure that their documentation reflects all of this. There were 15 of 16 current OT/PT evaluations and ISPs submitted for Sample P.1. Again, the exception was Individual #888, as described above. Timeliness of the current OT/PT assessments was as follows:	

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		• 13 of 15 individuals' OT/PT assessments or updates (87%) were dated as completed at least 10 working days prior to the annual ISP. This was an improvement from 61% in the previous review. Based on signature dates and actual working days, the following assessments did not appear to have been completed 10 working days prior to the ISP: Individual #43 and Individual #80. Both of these were completed prior to the ISP. The percentage for the most current assessments was 91%, representing a substantial improvement from 78% since the previous review. In the previous review, the timeliness of assessments was 100% compliance (i.e., the current percentage was a decrease). • 15 of 15 assessments (100%) were current within 12 months for individuals in Sample P.1 who were provided PNM supports and services (an assessment was not indicated for Individual #888). This was consistent with the previous review. OT/PT Assessment Only current Comprehensive Assessments completed in the last six months for individuals in Sample P.1 were included in the following analysis (Individual #629). Two additional Comprehensive Assessments were submitted as most current for OT/PT clinicians (Individual #264 and Individual #554) and had been completed in the last six months. 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 assessments was as follows: • 8 of 8 assessments (100%) were signed and dated by both OT and PT clinicians upon completion of the written report. This was an improvement from 93% in the previous review. • 8 of 8 assessments (100%) included medical diagnoses. This was consistent with the previous review. • 8 of 8 assessments (100%) included medical history. This was consistent with the previous review. • 2 of 8 assessments (25%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. This was a decrease from 43% in the previous review. • 1 of 8 assessments (13%) addressed health status over the last year. This was a decrease from 79% in the previous review. • 2 of 8 assessments (25%) included comparative analysis that clearly analyzed health status compared with previous years or assessments. This was a decrease from 36% in the previous review. • 4 of 8 assessments (50%) included a section that reported health risk levels that were associated with PNM supports (the exceptions included Individual #629, Individual #703, Individual #988, and Individual #462). Though they were newly	

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		admitted, the risks that were identified by the OT and/or PT based on these assessment findings should be discussed in the assessment. This was a decrease from 71% in the previous review. • 8 of 8 assessments (100%) listed medications and potential side effects relevant to functional status. This was an improvement from 93% in the previous review. • 8 of 8 assessments (100%) included individual preferences, strengths, and needs. This was an improvement from 93% in the previous review. • 7 of 8 assessments (88%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). It appeared that the only setting for observation alternate to the therapy clinic was mealtimes. Observations should be conducted in the home and work settings to ensure that a full understanding of the individual's functional skill levels, potentials, and needs are documented. This was an improvement from the previous review. • 8 of 8 assessments (100%) 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 93% in the previous review. • None of these individuals required a wheelchair for mobility, so the following metric was not applied: % of assessments included a description of the current seating system with a rationale for each component and need for changes to the system were outlined as indicated, also with sufficient rationale. • 0 of 4 assessments (0%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. Four individuals were newly admitted to MSSLC. The frequency and findings of monitoring were not reported in any case. This was consistent with the previous review. • 3 of 4 assessments (75%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. This was a decrease from 79% in the previous review. Individual #629, Individual #451, Individual #462, and Individual #703 were newly admitted to MSSLC, so this information may not have been available. • 8 of 8 assessments (100%) included documentation of the efficacy and/or introduction of new supports in the PNMP that address the individual's PNM risk levels. This was an improvement from 90% in the previous review. • 8 of 8 assessments (100%) included discussion of the individual's potential to develop new functional skills. This was an improvement from 23%. All individuals were functional related to motor skills and ADL, with the exception of Individual #629, who made it clear he would not tolerate intervention. Direct therapy was recommended for Individual #703 and Individual #988. • 8 of 8 assessments (100%) identified need for direct or indirect OT and/or PT	

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		services, and provided recommendations for direct OT/PT interventions and/or skill acquisition programs as indicated for individuals with identified needs. This was consistent with the previous review. • 0 of 8 assessments (0%) included a monitoring schedule. This was consistent with the previous review. • 8 of 8 assessments (100%) included a re-assessment schedule. This was an improvement from 86% in the previous review. • 8 of 8 assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This was consistent with the previous review. • 0 of 8 assessments (0%) detailed the supports and services needed for successful community living. There was no discussion of environmental adaptations needed for home or work, level of supervision, or needs for OT and/or PT services. This section should provide an overview of special indications that should be considered if the individual was going to transition to the community from the perspective of the OT and PT. This was a decrease from 43% in the previous review. • 8 of 8 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 active 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 was a new assessment format recently developed by the state and distributed. These contained standardized main headings that were to be used by all disciplines. The facility had implemented these changes. Further findings related to OT/PT assessments as follows: • None of the assessments contained 100% of the 22 elements listed above. There were improvements in seven of the elements. • There was a decrease for six elements. • Eight elements were consistent with the previous review, though two of these remained at 0%. There were 11 individuals in Sample P.1 for whom records were submitted with current Updates/Assessments of Current Status, but only one had an associated Comprehensive	

#	Provision	Assessment of Status	Compliance
		Assessment submitted and/or contained in the records (Individual #376). • For 9 of 10 individuals for whom Updates/Assessments of Current Status were completed (90%), the updates provided the individuals' current status, a description of the interventions that were provided and effectiveness of the interventions and re-assessment schedule. These did not include relevant clinical indicator data with a comparison to the previous year (exceptions included Individual #197, Individual #80 and Individual #441) or monitoring data from the previous year and monitoring schedules. There was typically no monitoring schedule identified in any assessment, but rather a generic statement that monitoring would be ongoing with the exception of Individual #376. There was considerable variation in the content of the ACSs reviewed. There was limited improvement in the content quality of OT/PT assessments for this review period, though timeliness for assessments was significantly improved. There was an audit system in place involving review for a sample of assessments, though this was conducted only at the time of the self-assessment for assessments submitted, rather than throughout the review period. This approach did not permit proper analysis of findings or the development of action plans to address weaknesses. MSSLC determined that they had not attained substantial compliance with provision P.1 and the monitoring team concurred. 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 the audit system promotes improvements in the content of OT/PT assessments at or near 90%, the standard held by the monitoring team. These audits should be conducted through the review period rather than only for the self-assessment to permit them to identify concerns and implement appropriate corrective actions and review these for effectiveness for improvement. 2. The ACS should address essential findings from the last year, but should not be equivalent to a full comprehensive assessment. This will permit these to be completed in less time and permit more opportunities for direct supports and interventions. The essential elements must be identified with specific guidelines established to ensure that there is improved consistency with these. This will also assist in the audit process for these assessments as well as the Comprehensive Assessments.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall	<u>Direct OT/PT Interventions:</u> There were 19 individuals listed as participating in direct OT and/or PT and eight of these were included for review in Sample P.3 (Individual #557, Individual #937, Individual	Noncompliance

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	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.	#697, Individual #988, Individual #524, Individual #873, Individual #376, and Individual #365). • For 4 of 8 individuals (50%), an OT/PT assessment or consult identified the need for OT/PT intervention with rationale. In the case of Individual #697, a screening was conducted that indicated he would benefit from OT intervention. Per the Settlement Agreement, when a screening was done and it was determined that the individual presented with OT/PT needs, a comprehensive assessment must be completed within 30 days of the identification of need. Over 30 days after the screening was completed a consult was completed which again recommended direct OT services. OT intervention was implemented on 3/26/14. There was no evidence of assessment for Individual #524 or Individual #376 to justify the need for direct intervention for PT. Though an IPN indicated that assessment had been conducted on 3/6/14, there was no documentation of the findings to justify the provision of PT services for Individual #365. There was a brief IPN stating that Individual #873 had been evaluated for PT intervention, but there was no baseline status documented and no rationale for treatment. In a notation on 4/24/14 in the treatment plan notes, there was another reference to assessment for PT intervention, but again there was no baseline established and no rationale for requiring direct PT services. There was no reference to an injury, though pain appeared to be an issue. Again, even this was not clearly stated in an assessment. • 6 of 8 individuals had direct intervention plans (75%) implemented within 30 days of creation (or sooner if indicated by the individual's health and safety), though a rationale for delaying implementation of PT for Individual #365 was identified in the IPNs. Individual #524 was not provided critical PT services related to a long bone fracture for nearly 10 days due to a "miscommunication between the PT and PTA," by report. • For 5 of 8 individuals (63%), there were objectives related to functional individual outcomes included in the treatment plan. Though there was a therapy intervention plan for Individual #524, the stated goals were related to her tolerance for a PT methodology, rather than an individual functional outcome. She had experienced a long bone fracture and it would be likely that there were a number of functional outcomes that should have been outlined related to direct PT services. There were no measurable goals established for Individual #937 or Individual #988. • For 2 of 8 individuals (25%), the treatment outcomes were documented in the ISP or ISPA (Individual #365 and Individual #524). The objectives were not stated in measurable terms, but only referred to general outcomes. • For 0 of 3 individuals (0%) whose therapy had been terminated, termination of the intervention was well justified and clearly documented in a timely manner (Individual #873). Though it was reported by the PTA providing treatment that he had met his goals and reached the end of the treatment plan, there was no	

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		discharge summary completed by the PT to summarize the course of treatment and progress with established goals and to determine if further interventions or other supports were indicated. A treatment plan note had been written by the PT on 6/3/14 for Individual #365 that he was being discharged from therapy. There was inadequate justification, only that he had not made progress over the last 30 days, but very limited clinical evidence of his status with each of the established goals was documented. The same was noted for Individual #376. The system for documentation was not consistent for each of the individuals reviewed. There was a combination of session notes and monthly progress reports. Some of these were in the IPNs and others were written on the treatment plans. There was duplication and redundancy in some cases and, in others, only a general statement of was in the IPN and a more detailed note was on the treatment plan form. Progress notes/IPNs: • Though therapy interventions for all eight individuals reviewed were routinely documented in IPNs or other method of progress notes, the content and format of these varied greatly across individuals and did not consistently include the following: 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. Additional SAPs developed for implementation by DSP staff with monitoring by OT/PT was not evident, with the exception of Individual #988. <u>Integration of OT/PT Interventions, Supports and Services in the ISP</u> Review of the PNMP and Dining Plans were required by the IDT at least annually during the ISP meeting. Likewise, all other supports and services provided through OT/PT should be reviewed by the IDT and well integrated into the ISP and/or ISPA. This requires that key team members be present, including the OT and/or PT clinicians. As described above, the ISPs or ISPAs for individuals in the sample who participated in direct OT or PT	

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		services did not consistently establish the need to begin or terminate therapy. The current system also required that the IDT designate which team members were required to attend the annual ISP during the pre-ISP meeting. Pre-ISP documentation and ISPs were requested for individuals included in Sample P1. Completed pre-ISP required attendance sheets were not submitted for five individuals: Individual #43, Individual #432, Individual #503, Individual #524, and Individual #441. A signature sheet for Individual #197 was not submitted. Review of the ISPs submitted was as follows: • 100% (16 of 16) of the ISPs submitted were current within the last 12 months. • 94% (15 of 16) of the current ISPs had attached signature sheets. • 40% (6 of 15) of the current ISPs with signature pages submitted were attended by both the OT and PT (Individual #118). • 20% (3 of 15) were attended by PT only. • 33% (5 of 15) were attended by OT only. • 7% (1 of 15) of the current ISPs had no representation by an OT or PT (Individual #888). Per his assessment, he did not have any identified OT/PT-related needs and attendance was not indicated per his pre-ISP. Of the 10 individuals for whom pre-ISP required attendance sheets and ISP signature sheets were submitted, four meetings were attended at least by the designated clinicians, though in some cases, additional therapists were present. In two cases, (Individual #577 and Individual #395), the IDT designated that OT, PT, and SLP were required to attend the ISP. In these cases, one or two of the three were present. In four other cases, no therapy clinicians were designated to attend, but at least one or more were noted to be in attendance. In some of these cases, the form appeared to be used as a signature sheet for the pre-ISP rather than to designate ISP attendance. 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. 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.	

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		3. 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, and report progress and termination with rationale. 4. There should be standardization of documentation of therapy services established. While the clinicians routinely documented treatment interventions, there was no assessment justifying these on a consistent basis. Additionally there was not an adequate discharge summary to review the course of treatment and provide justification for termination.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	<u>Competency-Based Training</u> Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs were addressed in detail in section O.5 above. Substantial compliance with O.5 is the standard for compliance with this element.	Substantial Compliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	The facility had a draft OT/PT policy dated 4/27/14, with no evidence that it had been finalized at the time of this review. While it generally addressed some of the following elements, the details of procedures were not outlined. Instead, there were general statements that the facility would ensure that assessments were completed and that monitoring would be conducted (for example), but the document would not guide an employee as to what specifically was expected and did not offer details for implementation. • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria; • 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;	Noncompliance

#	Provision	Assessment of Status	Compliance
		• 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. While it was not necessary that a policy document include all of the implementation details, these should be contained in a procedural document/employee handbook to ensure that all staff understand the specifics of service provision and their roles and responsibilities as an OT or PT at MSSLC. <u>Monitoring System</u> Per the draft policy described above, MSSLC implemented a system for compliance monitoring of the implementation of PNMPs conducted by the Habilitation Therapy staff, though this was completed by therapists only in conjunction with effectiveness monitoring. This was done by the PNMPCs at one time, but was discontinued over a year ago and had not yet resumed. A plan was in place to resume this process in the near future, by report. This monitoring included staff compliance for implementation of PNMPs/Dining Plans and the condition and availability of adaptive equipment. There was no standardized system to ensure routine and consistent monitoring of staff related to implementation based on individuals and their established risk levels. • The tools included adequate indicators to determine whether staff demonstrated competency to safely and appropriately implement the PNMP, though these were generic in nature and it was not always clear what was monitored. For example, in the case of Individual #524, she was monitored for positioning on 5/8/14. It was not clear if positioning in bed, a chair, and/or wheelchair was observed. This was noted on a number of the forms submitted for review. During the course of the month, monitoring was conducted for positioning and lifting/transfers, but there was no evidence that other aspects of the PNMP were monitored. • There were sufficient instructional guidelines for those using the forms to monitor. • It was not clear what training had been provided to therapy staff relative to the process of monitoring the elements of the PNMP. It did not appear that all areas of the PNMP had been consistently monitored based on the forms submitted (three months of monitoring for each individual in Sample P.1 was requested). There were no recommendations as to the frequency of compliance monitoring required for the individuals in the Sample P.1 in their annual assessments. Additionally, there were no guidelines provided to therapists to guide the frequency of	

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		PNMP/Dining Plan monitoring in a systematic and consistent manner. There was also a system established for effectiveness monitoring by the therapists, though the intended frequency of this was also not clear based on the annual assessments submitted. Effectiveness monitoring guidelines should be developed to indicate that this should occur as follows: • Monitor upon initiating a new plan • Monitor upon modifying a plan • Monitor following identified issues or concerns • Monitor no less than quarterly, unless there was a clear rationale Based on the sample of individuals selected for P.1, evidence of effectiveness monitoring for each was requested for the last six months. This was provided for December 2013 through May 2014 for 12 of 16 individuals. No forms were submitted for Individual #43, Individual #395, Individual #441, and Individual #888. The compliance monitoring form included a section that addressed effectiveness monitoring and both were conducted in conjunction by OT and/or PT and assistants. Fifteen forms addressed the effectiveness of the Dining Plan for six individuals. Four forms addressed medication administration for three individuals. Three forms addressed oral care for one individual. One form addressed bathing for one individual. All others were related to the positioning and lifting/transfers (42). Nine were completed by assistants for staff compliance monitoring only and each of the others included both staff compliance and program effectiveness. It was of concern that there did not appear to be a method to ensure routine monitoring of either type based on risk levels and service needs. In addition, only portions of the plans were monitored at any given time, rather than an assertion that the entire plan was effective. The entire PNMP should be monitored at least quarterly, though it may be established less frequently based on specific needs and risk levels. This should be identified in the annual assessment and reviewed and approved by the IDT and documented in the ISP/ISPA. • Based on the monitoring team's direct observations, over 90% of positioning devices and mealtime adaptive equipment identified in the PNMP were clean and in proper working condition. • Based on review of the maintenance log, individuals for whom adaptive equipment was noted to be in disrepair or needing replacement, equipment was repaired or replaced within 30 days, or unless the issue impacted the individual's health or safety, then action was taken within 48 hours. There was also evidence of routine maintenance checks. This element was self-rated to be in noncompliance. There was no well-established or	

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		consistently implemented system of compliance and effectiveness monitoring 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. Establish benchmarks, a tracking system and schedule for effectiveness monitoring by OTs and PTs. It appeared that some monitoring was done, but there was no clear method to determine if all areas of the PNMP were addressed at an established frequency. Effectiveness monitoring of the Dining Plan appeared to occur infrequently. 2. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. 3. Develop procedural guidelines to outline specifics of each of the elements of service provision as outlined in the SA.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: 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, 4/24/14 o MSSLC Facility Policy and Procedure Manual Policy #34 Dental Missed Appointments, 3/27/14 o MSSLC Facility Policy and Procedure Manual Policy #35 Dental–Oral Suction Tooth Brush, 4/10/14 o MSSLC Facility Policy and Procedure Manual Policy Dental Emergencies #36, 3/19/14 o MSSLC Facility Policy and Procedure Manual Policy #37, Dental Services Overview, 5/22/14(D) 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 #605, Individual #198, Individual #568, Individual #468, Individual #76, Individual #580, Individual #331, Individual #771, Individual #21 o Oral Surgery Consultations • Individual #64, Individual #268, Individual #502 Individual #432, Individual #790, Individual #386, Individual #101, Individual #816, Individual #284, Individual #297, Individual #649 Individual #143 Individual #895 Individual #779, Individual #784, Individual #133 Individual #479, Individual #381, Individual #150, Individual #446, Individual #300, Individual #554, Individual #484, Individual #872 Individual #98, Individual #944 Individual #237, Individual #801, Individual #639 Individual #703, Individual #901, Individual #972 o Annual Dental Summaries for the following individuals: • Individual #281, Individual #916, Individual #484 Individual #140, Individual #494, Individual #197, Individual #557, Individual #683, Individual #519, Individual #517, Individual #96, Individual #65, Individual #437 Individual #257, Individual #185,

	Interviews and Meetings Held: o Jimmy Tompkins, DDS, Dental Director o Richard Stimson, DDS, Staff Dentist o Christopher Ellis, MD, Medical Director o Sandra German, Administrative Assistant Observations Conducted: o Dental Clinic o Dental Desensitization Meeting o Medical Review Committee
	Facility Self-Assessment: The facility used the standard state self-assessment, which included 25 items for section Q1, and 14 items for section Q2. Each item listed an activity, then provided a result. A self-rating was made based on the results of the activities. The self-assessment did little to detect some fundamental issues, such as the provision of some basic services. That is, there was no metric that really determined if adequate services were provided. Because of that, the facility believed it was in substantial compliance with Q1 even though it did not have the ability to provide a number of basic dental services. In moving forward, the dental director should read this report, noting the comments and recommendations. Future self-assessments should continue to follow the template required by state office. Increased attention should be given to finding metrics that will accurately assess the provision of services.
	Summary of Monitor's Assessment: The dental department continued to make incremental measures of progress. Individuals were seen in a timely manner for annual and initial assessments and documentation of the assessments continued to improve. The suction toothbrushing program was expanded and additional oversight was implemented to ensure that treatments were adequately completed. Suction toothbrushing was an important part of the facility's efforts to improve oral hygiene ratings. The facility reported very few individuals with poor ratings. Compliance with obtaining radiographs improved with less than 10% of individuals having outstanding needs for radiographs. The dental services policy was revised (draft) to reflect the ADA guidelines for obtaining radiographs. There remained some concerns with the dental care at the facility, which prevented the monitoring team from agreeing with the facility's self-rating of substantial compliance for provision Q1. At the time of the compliance review, the facility did not use pretreatment sedation or TIVA on campus. Contracts for completing general dentistry work with sedation and/or anesthesia had been recently executed. This

	represented a significant accomplishment for the facility and the dental director should be commended for moving forward and securing such important services for the individuals. At the time of the compliance review, no individuals had actually completed any treatment through the providers, though a few individuals had undergone initial evaluations. The result of not being able to do general dental procedures with sedation/anesthesia was that individuals did not have access to these services. Oral surgery with sedation and anesthesia was available, but the services offered by oral surgeons differ from that offered by general dentists. Some individuals ultimately received services by an oral surgeon and had procedures expanded due to "rampant" decay and gross caries. Some of these individuals had lived at MSSLC for several years. The facility will need to demonstrate that it is adequately providing services in order to move towards achieving substantial compliance. This will require more than indicating that contracts have been executed for community services. There will need to be evidence that individuals are actually appropriately receiving those services. Finally, the monitoring team would like to comment on the submission of data for this review. The reporting period was October 2013 – March 2014. The clinic submitted data for November 2013 through April 2014. Data submitted for each compliance review should be consistent with data submitted for the self-assessment. Facility staff should also be cautious when submitting spreadsheets for requested lists. The monitoring team requested the appointment schedule for oral surgery. The clinic submitted an excel spreadsheet that included data that were not needed by the monitoring team rather than submit a list that included the names, dates of appointments, and procedures for consults completed. In order to determine what procedures the individuals had completed, the monitoring team had to read hundreds of pages of documents to obtain basic information.

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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 and dental director. <u>Staffing</u> The dental clinic continued under the direction of the full time dental director. A new dentist was hired 5/21/14 to fill the vacancy created by the departure of the staff dentist who resigned in April 2014. There were two full time registered dental hygienists, a dental assistant and an administrative assistant. One dental assistant position remained vacant. <u>Annual Assessments</u> The monitoring team requested a list of annual assessments completed in the last six months, listed by month. The facility submitted a list of assessments completed each month. Assessments were completed within 365 days of the previous assessment. The data from the documents submitted are presented in the table below.	Noncompliance

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Annual Assessment Compliance 2013 - 2014						
	Nov	Dec	Jan	Feb	Mar	Apr
No. of Exams Completed	24	28	30	22	24	14
% Timely Completion	100	100	100	91	100	100

The average compliance for the five-month reporting period was 98%.

Ten Annual Dental Examinations were submitted as part of the complete records. The Dental Record Annual Examination included information on behavior classification, oral hygiene, tissues, management needs, medical/physical limitations, medical history, intra-extra oral exam, periodontal disease, caries, and radiographs. The assessments did not include information on positioning and suctioning toothbrushing. That was included in the new state template that was issued in February 2014. For the records reviewed, the state template was not utilized. Six of the 10 complete dental records included annual exams completed after February 2014, but none of the assessments utilized the new template. Several of the assessments were completed in April 2014 and should have been done utilizing the new template.

The Annual Dental Summary was a chart review completed in preparation for the ISP. A state issued template was implemented in December 2013. This summary included information on current oral hygiene, tissue status, and use of sedation. It also documented periodontal condition and each assessment included an odontogram. The use of the odontogram key required a color copy for interpretation. It was not helpful in black and white copies. Comments related to preferences, strengths, goals, and community living and services were included.

Copies of 16 Annual Dental Summaries were submitted for review. The following summarizes the data included in those documents:

- 16 of 16 (100%) had an entry concerning behavioral issues, and the need for sedation/restraint use
- 16 of 16 (100%) documented oral hygiene status
- 16 of 16 (100%) documented oral cavity tissues
- 16 of 16 (100%) included a completed odontogram
- 16 of 16 (100%) documented treatment recommendations
- 16 of 16 (100%) documented risk ratings specific to periodontal disease and caries
- 16 of 16 (100%) documented the dates of the last radiographs
- 16 of 16 (100%) included comment on community and living services
- 16 of 16 (100%) included comments on preferences, strengths, and goals.
- 1 of 16 (8%) assessments was not completed

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		Initial Exams Thirty individuals were admitted from November 2013 – March 2014. The assessments for all individuals were completed within 30 days of admission. Oral Hygiene The facility continued to monitor the oral hygiene ratings of the individuals. The following data were reported: Oral Hygiene Ratings 2013 -2014 (%) Nov: Good 70, Fair 30, Poor 0 Dec: Good 50, Fair 46, Poor 4 Jan: Good 40, Fair 53, Poor 7 Feb: Good 47, Fair 53, Poor 0 Mar: Good 67, Fair 33, Poor 0 Oral hygiene ratings were recorded with all dental evaluations and the individual's oral health was addressed. The numbers reported in the table above reflected the ratings documented in the annual and initial evaluations. Individuals with a poor rating were placed on a one-week recall until they completed two to three consecutive appointments with fair or good ratings. If the oral hygiene improved, the individual was placed on a two to three month recall. If there was no improvement, the dentist wrote an order for the IDT to meet regarding the poor oral hygiene rating. Beginning 10/15/13, the clinic began randomly selecting direct support professionals who attended clinic to demonstrate proper oral hygiene techniques in clinic. The clinic continued to use plaque index scores as a more objective means of determining oral hygiene ratings. Overall, the facility had very few individuals with poor hygiene ratings. Suction Toothbrushing Thirty-seven individuals received suction toothbrushing. These were individuals who were at risk, such as those with a history of pneumonia or those with enteral feeding tubes. The treatments were provided by the direct support professionals. Effective 5/1/14, monitoring was conducted once a month by the clinic RDHs who used a monitoring form. Home staff had implemented monthly monitoring that was sent to the dentist. The plan was to present this data quarterly at MRC. A facility licensed vocational nurse was assigned the responsibility of training the staff and ensuring that the treatments were properly done.	

#	Provision	Assessment of Status	Compliance
		Preventive, Restorative, and Emergency Services MSSLC operated a full time 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. The total number of clinic visits and key category visits are summarized below.	

Clinic Appointments 2013 - 2014					
	Nov	Dec	Jan	Feb	Mar
Preventive	129	149	171	153	165
S&W FU	4	1	6	2	5
Referrals	13	5	8	21	0
Extractions	0	0	0	0	0
Toothbrushing	27	32	31	17	34
Desensitization	3	3	1	0	1
Emergency	0	0	1	0	1
Restorative	55	54	47	39	57
Completed Appointments	184	203	219	192	223

Preventive care appointments included annual and initial assessments, referrals, and Scott and White follow-up appointments. Restorative appointments included those for fillings, impressions for partials, adjustments, and delivery of partials and dentures.

There were no extractions done at MSSLC. For the months of October 2013 through March 2014, 16 individuals had extractions done at Scott and White. The monitoring team found this to be a very unusual finding. Extractions of impacted and carious third molars were done. Documentation indicated there were individuals with extractions of multiple decayed teeth that were not molars. There were also individuals who had relatively simple extractions completed with local anesthesia. It was not clear why MSSLC was no longer doing any extractions in the dental clinic.

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. The facility had acquired portable x-ray equipment just prior to the December 2013 compliance review. This resulted in increasing compliance with obtaining

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		radiographs. MSSLC documented that 9% of individuals did not have current radiographs. A two-year standard was utilized to determine compliance. The monitoring team found documentation of radiographs or attempts to obtain radiographs in the annual assessments reviewed. The dental services policy was revised to include the ADA guidelines for obtaining radiographs. That policy remained in draft at the time of the compliance review. <u>Oral Surgery</u> There were 32 individuals referred to the oral surgeons at Scott and White from November 2013 to April 2014. The monitoring team reviewed the consult notes and IPNs submitted for the 32 individuals. The following are a few examples of information taken from the documents reviewed: • Individual #779 was referred to Scott and White for extraction of tooth #32 and tooth #1 due to dental caries. • Individual #784 had extraction of multiple carious teeth. • Individual #432 had extraction of multiple teeth with "gross carries." • Individual #816 had documentation by the oral surgeon that "caries continue to be fairly advanced," hygiene was poor and teeth were decayed to the gumline. • Individual #639 was referred to Scott and White for removal of tooth #30 and tooth #18. Tooth 30 was removed with <u>only local anesthesia</u>. The oral surgeon documented nothing unusual about the extraction. No sutures were required and no follow-up to Scott and White was needed. In the cases of the individuals with dental caries, several had lived at MSSLC for some time. The deterioration of oral health to the point in which multiple extractions are required raises concerns, specifically those related to home care and the facility's management of refusals. The documentation indicated that individuals may have been referred for extraction of third molars, but other teeth were removed due to caries. In some cases, the oral surgeons appeared to do simple extractions of a single tooth with local anesthesia and no pretreatment sedation. This would be similar to what could be done in the facility clinic. Thus, the monitoring team was not clear on why such extractions could not be accomplished in the MSSLC clinic. As previously noted, the practice of performing no extractions in the clinic is a new one that may be appropriate, but is worthy of review by the state dental services coordinator. The requests for these referrals should also be more intensely vetted through the MRC approval process.	

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		In addition to the examples of obvious dental pathology, there were cases in which the outcome of the consult was pending. In some instances, it appeared that follow-up did not occur or documentation was not submitted: • Individual #64 did not have surgery due to the inability to locate family for consent on 1/21/14. Surgery was cancelled. • The consultant documented on 11/13/13 that a discussion would occur with the MSSLC dentist about proposed treatment for Individual #649, but no follow-up was documented. <u>Sedation/General Anesthesia/TIVA</u> The facility did not utilize any oral sedation for the clinic and TIVA was not used. According to the medical director, there was no plan to move forward with using TIVA at MSSLC. One of the major limitations of dental services for the facility was the lack of the ability to provide non-surgical dental services with the use of anesthesia. Individuals who required sedation or TIVA or who needed to have dental work performed in a hospital setting were not provided adequate services. TIVA and anxiolysis were not offered on campus and until recently, the facility did not have any contracts with community providers to perform these services. In recent months, two contracts were secured. One contract with Scott and White would allow general dentists to perform work with anesthesia or other types of sedation. The second contract was with a dental anesthesiologist at another clinic that would also allow individuals to have general dental procedures done with the use of anesthesia. The agreement with Scott and White oral surgery remained intact. The clinical impact of this was quite noticeable. Prior to securing the contracts, if an individual required dental procedures by a general dentist with the use of sedation or anesthesia, there were few options. Some individuals required an oral surgeon for impacted third molars, hyper-erupted third molars, or other issues. The monitoring team observed that those individuals often had multiple additional extractions for dental caries not related to the original consultation. The facility's lack of use of any sedation has been questioned by the monitoring team for some time. The monitoring team was specifically interested in learning why the facility did not utilize any pretreatment sedation (e.g., single dose of oral medication), which would be administered prior to the arrival to dental clinic because this may have allowed some individuals to complete treatment with minimal risk. The dental director indicated that the use of any medication required that dentists have specialized training and none of the facility dentists had such training.	

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		The monitoring team is not recommending the use of pretreatment sedation or TIVA, but strongly recommends that the state dental services coordinator review the current practices and plans for future practices at the facility to determine if they are appropriate for the population served and resources available. <u>Staff Training</u> All new staff received competency-based training. Hands-on skills trainings were provided in the 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> This provision remains in noncompliance. To move in the direction of substantial compliance, the monitoring team makes the following recommendations: 1. The facility needs to proceed with implementing the state annual assessment template. 2. The facility must provide the appropriate services for all individuals inclusive of general dentistry with the use of the various levels of anesthesia.	
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'	<u>Policies and Procedures</u> The monitoring team requested all facility (local) policies related to the provision of dental care. MSSLC submitted several policies, all of which are listed above under the documents reviewed. The dental director addressed a number of issues through policy revision, including suction toothbrushing, missed appointments, emergency dental treatment, and dental radiographs. The dental radiograph requirement was added to the general dental policy, which remained in draft at the time of the compliance 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	Noncompliance

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	refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	• Anesthesia - medical clearance, recovery • General anesthesia personnel • Infection control • Training • Dental emergencies • Oral care Some policies may not be under the purview of the dental department, however, policies such as informed consent and the HRC review process should also be included the manual. 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. Dental Records 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. Documentation in the assessments is discussed in section Q1. Failed Appointments MSSLC utilized the following definitions for appointments: • Missed - A missed appointment was an appointment that was scheduled, but not attended. • Refusal -A refusal was an appointment that was scheduled, but the individual verbally refused to attend. • No show - A no show was an appointment that was scheduled, but the individual did not have knowledge of and did not attend. • Re-scheduled- Rescheduled appointments were appointments cancelled by the dental clinic. These cancelations were due to a lack of dental clinic staff or issues such as lack of water, fire evacuation, inclement weather, and jury duty. The number of appointments as identified and reported by MSSLC are summarized in the table below:	

Failed Clinic Appointments 2013 - 2014					
	Nov	Dec	Jan	Feb	Mar
No Show	23	27	56	27	35
Rescheduled	11	17	14	4	42
Refused	8	7	10	8	10
Missed (Failed)	42	51	80	39	87
% Failed	18.5	20	26.7	16.8	28
Total Sched Appointments	226	254	299	231	310

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		The facility had a significantly high failure rate, averaging 22% for the five months reported. The no-show appointments were primarily due to conflicts with other scheduled appointments, home visits, and furloughs. The lack of centralized scheduling appeared to be the root cause. The clinic had taken a number of steps to decrease no-shows. The homes received the dental schedule two weeks prior to the scheduled appointments and daily reminders were sent to all homes. Additionally, the clinic called each home to remind staff of scheduled appointments. The monitoring team observed that missed appointments were discussed daily in the clinical services meeting. A significant number of failed appointments were due to clinic cancellations. For the 88 rescheduled appointments reported for November 2013 through March 2014, 25 of 88 (28%) were due to lack of clinic staff. Facility management will need to conduct further reviews if this rescheduling pattern continues. Refusals will be discussed below. <u>Sedation and Dental Restraints</u> The facility documented that, for the reporting period, 0% of individuals receiving treatment used general anesthesia and 0% required sedation for on-campus treatment. The dental department did not utilize mechanical restraints. Some individuals received pretreatment sedation off campus. This was not reported as part of the facility data. The dental director explained that this was part of the anesthesia protocol. <u>Strategies to Overcome Barriers to Dental Treatment</u> When an individual refused treatment two or three times, the dentist wrote an order to have the IDT develop strategies to address the refusals. Refusals were also reported at the daily clinical services meeting. The monitoring team attended the monthly desensitization committee where individuals who refused dental treatment or exhibited difficult behaviors in clinic were discussed and a disposition and recommendations were made. The committee also reviewed medication refusals, and received reports on a number of other issues. Documents for three individuals who refused dental treatment (Individual #508, Individual #297, Individual #310) were reviewed. It could not be determined from those documents what the outcomes were for the individuals because no updates were provided. However, Individual #297 subsequently had a full mouth extraction. Four individuals were documented to have desensitization plans implemented in 2013. One of the individuals expired in March 2014. The monitoring team reviewed documents related to the plans for Individual #484 and Individual #1. The plans appeared to	

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		appropriately address the issues. During discussions with the dental director, the definition of refusals was reviewed. He noted that individuals who came to the clinic, but refused treatment were not counted as refusals, but were considered to have alternative treatments. He used Individual #732 as an example. In doing this, the facility was carrying out an informal desensitization plan, but this was not captured by any of the data reported. Record documentation by hygienists simply noted that individuals refused treatment. This procedure appeared to work for some individuals. For example, Individual #605 was seen in clinic multiple times and refused treatment. The clinic continued to reschedule appointments and the individual gradually allowed more treatment. The monitoring team was pleased to see these types of opportunities being presented to individuals, but was concerned about the informality of the process. Informal desensitization plans and alternative treatments were not reviewed and had no oversight to ensure that progress was made, treatment was not delayed, and dental disease did not progress resulting in non-restorable teeth. <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 monitoring team offers the following recommendations for consideration: 1. The dental director should address the need to develop a comprehensive dental clinic manual. 2. All individuals who <u>refuse</u> dental treatment should be tracked by the dental clinic. Consideration should be given to how informal desensitization should be monitored for effectiveness. 3. The facility must address the problems with failed clinic appointments.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Admissions List o Budgeted, Filled and Unfilled Positions list, Section I o Section R Presentation Book o Facility Self-Assessment, Action Plans and Provision of Information o Section R QA Reports 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 individuals with PBSPs o Tracking log of SLP assessments completed since the last review o SLP/Communication assessment 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 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 o List of individuals with communication-related SAPs o Communication Supports Monitoring forms submitted o Summary reports or analyses of monitoring results o Staff training data submitted o Communication Assessments for individuals recently admitted to MSSLC: Individual #872, Individual #629, Individual #697, Individual #937, Individual #696. o Communication Assessments, ISPs, ISPAs, SAPs, intervention plans, IPNs, and other documentation related to communication, including monitoring forms, for the following individuals: ▪ Individual #321, Individual #895, Individual #784, Individual #320, Individual #272, Individual #101, Individual #300 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #43, Individual #432, Individual #188, Individual #395, Individual #503, Individual #524, Individual #80, Individual #629, Individual #376, Individual #407, Individual #597, Individual #197, Individual #117, Individual #441, Individual #888, and Individual #577.

	○ PNMP section in Individual Notebooks for the following: • Individual #43, Individual #432, Individual #188, Individual #395, Individual #503, Individual #524, Individual #80, Individual #629, Individual #376, Individual #407, Individual #597, Individual #197, Individual #117, Individual #441, Individual #888, and Individual #577. ○ Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #43, Individual #432, Individual #188, Individual #395, Individual #503, Individual #524, Individual #80, Individual #629, Individual #376, Individual #407, Individual #597, Individual #197, Individual #117, Individual #441, Individual #888, and Individual #577. <u>Interviews and Meetings Held</u>: ○ Sandra Opersteny, PT, Habilitation Therapies Director ○ Lisa Finley, COTA ○ Lauren George, MS, CCC-SLP ○ Various supervisors and direct support staff <u>Observations Conducted</u>: ○ Living areas ○ Dining rooms ○ Day program areas ○ ISP for Individual #557 ○ Pre-ISP for Individual #497
	Facility Self-Assessment: The self-assessment completed by Sandra Opersteny, PT, Habilitation Therapies Director, and Lisa Finley, COTA, was improved from the last review. Activities listed as conducted were relevant. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of elements were addressed and used to determine compliance. Findings were consistently reported in measurable terms, though inaccuracies and in consistencies were identified by the monitoring team. Though the self-assessment seemed to be created for the monitoring team, this should be a process used by the department to track and determine progress with the elements of the Settlement Agreement and to direct the necessary actions to effectively focus staffing, administrative supports, and oversight. 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, in general, continued to demonstrate hard work and a focus on accomplishing their established goals, though this was significantly diminished relative to communication supports and services. There was ongoing turnover of staff during the last six months. There was limited clinical expertise and leadership as evidenced by the lack of adequate

	assessments and a poverty of AAC. The department leadership determined that a reduced review was indicated because minimal progress had been made during the last six months. The facility rated itself in noncompliance with R.1 through R.4 and the monitoring team concurred. MSSLC supported a significant number of individuals with severe communication deficits and, as such, it is critical that caseloads be sufficiently smaller to ensure that adequate and appropriate supports are provided. There is a need for strong clinical leadership to increase the adequacy of assessments and AAC supports and services. Additionally, a focus on staff training and monitoring related to AAC and communication, and consistency and quality of effectiveness monitoring were indicated. 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. Review the identified needs of individuals living at MSSLC to determine the actual resource requirements for communication therapists. 2. Continue to aggressively recruit at least one full-time SLP (or retain the current contract staff on an ongoing full-time basis). 3. Further coaching and monitoring of speech clinicians will be necessary to achieve compliance with the essential elements for communication assessments. 4. Consider the identification of clinical leadership related to communication supports and services. Ensure that the information in the communication assessment related to the PBSP is well integrated. Ensure that communication strategies are effectively translated into the PBSP and consistent with the individual's function and methods of communication. Implement methods to integrate communication supports and services with behavioral health services. 5. Ensure that information related to communication is effectively translated to the ISP. 6. Ensure collaboration of SLPs in the integration of SAPs for individuals with communication deficits in need of specific strategies to enhance interactions with communication partners. 7. Establish a system to ensure that staff are monitored routinely to carry out communication plans and provide supports. There was currently no method for staff to participate in annual training, so monitoring and the provision of routine coaching is critical. 8. Establish clear procedural guidelines for effectiveness monitoring and include documentation guidelines to enhance consistency. Review use of the IPNs and consider guidelines to ensure that all elements are included. 9. Track findings of both effectiveness and compliance monitoring. Audit for timely completion of each as per the recommendations in the assessment or other established guidelines. Ensure that these findings are included in annual communication assessments for individuals and that the recommended interval for review was clearly outlined.
	Summary of Monitor's Assessment: There was a weakness in the assessment process to determine AAC needs in both Comprehensive Assessments and Assessments of Current Status. Timeliness of assessments was poor, though attendance

	at ISPs was improved. A number of individuals participated in traditional speech therapy for articulation disorders. The documentation of this therapy was consistent and appropriate. There was no clear evidence of an effort to work collaboratively with behavioral health to develop communication strategies that were well-integrated into the PBSP and throughout the daily routine. AAC usage was very limited with only a handful of individuals having communication systems and supports. There were very few communication systems in place. SAPs related to communication were developed by the program developers, but with little evidence of participation by the SLPs in their development, implementation, or review. There are key aspects of section R that require evidence of integration into the ISP annually and during interim ISPAs. This must include actual documentation that the IDT reviewed the communication dictionary, communication plans and supports, and that the IDT specifically identified the effectiveness and any need for changes. Based on observations, discussions occurred, but integration must follow through to inclusion in the ISP document and in the implementation of supports and services. While there were notable improvements in Martin relative to PNM supports for health and safety, there was little change noted related to active treatment and meaningful engagement. The facility continued to struggle with focusing on what was most meaningful and what were the most fundamental needs of the individual with consistent implementation of SAPs and group activities based on these. It was observed that, unless an individual was engaged in eating or routine daily care, there was little to no meaningful engagement or functional activities occurring in these homes. This must begin with the assessments that build the ISPs so that the IDT can effectively identify and develop skill acquisition for individuals. Additionally, there should also be a concerted effort to develop ideas for leisure engagement that also is meaningful and interesting. In Martin, many individuals were sitting with nothing to do and no one interacting with them. In one case, five men were sitting alone in different parts of the room. One man had a red cup with very old wooden pieces that he dumped and put back into the cup repeatedly. Two individuals were at a table with two staff who took out a Bingo game when they saw the monitoring team. In the ISP meeting observed this week, there was a presentation for a potential skill acquisition plan for an individual to use a key to the home. It was reported that an assessment had been conducted and it was determined that the individual had the manual dexterity to use a key, but was not able to distinguish it from other common objects. Based on these findings it was determined that he was not eligible for a SAP to use a key. Five minutes earlier, however, there had been a discussion related to his ability to communicate that he wanted tobacco by touching the key hanging from the home manager's neck that unlocked it. That is, he clearly understood the function of a key. Those who develop skill acquisition plans need input from specialists in specific areas to enhance the objectives and, relative to R, assist in integrating appropriate communication strategies into the plans. <u>The following samples were used by the monitoring team:</u> • Sample R.1: 16 individuals included in the sample selected by the monitoring team. • Sample R.2: Individuals admitted since the last compliance review. • Sample R.3: Individuals with AAC systems selected by the monitoring team • Sample R.4: Individuals receiving direct speech services (5)

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	The parties agreed that 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> There were two full-time SLPs with responsibilities related to communication, but who also shared responsibilities related to mealtime and dysphagia with OT. They were David Ehrenfeld, MA, CCC-SLP, and Lauren George, MS, CCC-SLP. Gloria Wells was a newly hired SLP (May 2014) and assigned to the PNMT. There was no communication-related caseload assignment for her, though it was reported that the PNMT therapists were responsible for new admission assessments. There were two full time speech assistants, Angela Bannworth and Christine Edwards. The facility identified five budgeted positions for SLPs with only one of those filled at the time of this review. Three contract clinicians were listed with each averaging 117 hours per month. FTEs were calculated as one, with a ratio of 1:75.5. Based on the reported census of 295, the current ratio was approximately 1:98.33. The SLPAs would not be considered as a part of this ratio because assessment was not a permitted scope of their practice, but rather served a key role to assist and support the SLPs and were licensed to provide direct intervention related to communication. Responsibilities of the full-time communication therapists included, but were not limited to, conducting assessments, developing and implementing programs, providing staff training, attendance at ISPs and ISPAs, and monitoring the implementation of programs related to communication and dysphagia. The full-time SLPs provided supervision to the SLPAs, as well as mentoring and training to the Habilitation Therapy technicians to enhance their competency in the monitoring of communication supports and services. The speech staff were assigned caseloads as follows per the documentation submitted (totals based on individual list by home and reported census of 295): • David Ehrenfeld: His communication-related responsibilities included Whiterock (approximately 63 individuals) and Shamrock 3 and 4 (approximately 9 individuals), for a total of 72 individuals, as well as supervision of the SLPA. • Lauren George: Her communication responsibilities included Martin 7 and 8 (approximately 17 individuals) and Barnett (approximately 53 individuals), for a total of 70 individuals, as well as supervision of the SLPAs. • Angela Bannworth: Her responsibilities included Martin (approximately 86 individuals) and Barnett 7 and 8 (approximately 15 individuals), for a total of	Noncompliance

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		101 individuals. • Christine Edwards: Her responsibilities included Whiterock 1-7 and 9 (at least 63 individuals, though home 9 was not identified in the census list submitted) and Barnett 1, 3, 4, and 6 (approximately 38 individuals), for a total of at least 101 individuals. There appeared to be no coverage for individuals living in Longhorn, parts of Shamrock, or Martin 1-6 by a SLP per document XV.3. Based on the self-assessment, there did not appear to be an established determination of the number of SLPs required to meet the needs of the individuals at MSSLC. There were approximately 61 individuals identified with significant communication needs (AAC, direct therapy, severe language deficits) with co-existing behavioral concerns. At the time of this review, it was stated that there were two vacancies based on the budgeted positions, though this did not appear to be based on any specific rationale. If all positions were filled, at the current census of 295, the caseload size would be approximately 59, a reasonable one if all individuals required supports and services. It did not appear to be well-established that all individuals at MSSLC required a SLP. This should be reviewed with a clear determination of resources needed to appropriately meet identified communication needs. Staffing had not remained stable since the previous onsite review, with only one of the same SLPs still employed. With two FTEs with communication-related responsibilities and two SLPAs, MSSLC did not appear to provide an adequate number of speech language pathologists with specialized training or experience to provide communication supports and services. <u>Qualifications:</u> • The facility documented appropriate qualifications for licensed SLPs. • 5 of 5 speech staff, with responsibilities related to communication (100%) were currently licensed to practice in Texas as verified online. This was consistent with the previous review. • 1 of 5 speech staff, with responsibilities for communication (20%) held current ASHA certification, though verification of this for the other four therapists was not requested by the monitoring team. These were presumed to be current. <u>Continuing Education:</u> Based on a review of continuing education completed since the previous review: • 3 of 5 current speech staff responsible for communication supports and services (60%) had completed continuing education in the last year related to	

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		communication in an area that was relevant to the population served. Continuing education attended by the three clinicians in the last year appeared to be relevant to communication and collectively included the following: • Low-Tech AAC Options and Practical Strategies for Classroom Use (1 contact hour) • Cognitive Rehabilitation of Children and Adolescents (Part 2): Favorite Strategies (1 contact hour) • Developing Strategies for Executive Function Deficits: A Group Model for Patient Treatment/Parent Training (1 contact hours) • Incorporating Phonemic and Phonological Awareness in Speech Therapy (1 contact hours) • Dysarthria: Practical Approaches to Understanding and Assessing (.20 CEUs) • Dysarthria: Practical Approaches to Treatment (.20 CEUs) • 6th Annual Social Thinking Providers Conference (18 contact hours) 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 or DADS-sponsored courses 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. There was a local policy related to communication in draft (4/27/14). The local policy should generally provide clear operationalized guidelines for the delivery of communication supports and services. This policy was general in nature and there were no other established procedures that clearly outlined the following elements: • 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	

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		intervention plans. • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution. Though the existing staff were well-qualified and experienced, there appeared to be an insufficient allocation of speech staff resources, based on the current census, though the actual need for communication supports and services was not clearly established The current staff ratio and caseload sizes were high at the time of this review. Limitation to caseload size is critical to ensure that clinicians are able to complete assessments in a timely manner, provide appropriate direct interventions, provide sufficient training, modeling and coaching for the implementation of communication programs, and to adequately maintain the necessary equipment. There was not a reasonable process to determine the number of qualified staff required and there was only a general policy with limited procedures that outlined the roles and responsibilities of the SLPs as described above. The monitoring team concurred with the self-assessment of noncompliance with this provision. In order to move towards substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Review the identified needs of individuals living at MSSLC to determine the actual resource requirements for communication therapists. 2. Continue to aggressively recruit at least one full time SLP (or retain the current contract staff on an ongoing full-time basis).	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	<u>Assessment Plan:</u> Assessments were appropriately completed per the ISP schedule, change in status, or per IDT request. By report, all individuals had been provided a Comprehensive Assessment. There was a tracking log of assessments completed from 10/30/13 through 5/9/14. As noted previously, the SLPs at MSSLC completed a Comprehensive Communication Evaluation and/or an Assessment of Current Status. At the time of this review, some changes had been made to the standard format for these reports per the state office and were in use as of 10/1/13. All individuals newly admitted to MSSLC were to be provided a comprehensive assessment of communication completed within 30 days of admission. All individuals were reported to have been provided a Comprehensive Assessment with subsequent Assessments of Current Status to be provided annually in the interim for individuals who received both direct and/or indirect services in years that a Comprehensive Evaluation was not required and as determined in the pre-ISP meeting. An additional assessment	Noncompliance

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		was to be completed with significant changes in status or per special IDT requests. Assessment due dates and timeliness of completion were maintained in the tracking log for individuals with ISPs scheduled from 11/13/13 through 6/6/14. Overall, per the self-assessment, there were 55 annual assessments completed from 10/30/13 through 5/9/14. There were 15 comprehensive assessments, 36 updates, and four screenings. Of these, only 25 were reported to be on time, 10 days prior to the ISP, 45% overall. For assessments due since 2/1/14, the on-time percentage was only slightly improved at 55%. There were 27 assessments listed in the tracking log for individuals newly admitted to MSSLC, nine were comprehensive and the others were screenings. Of those, 24 were listed as completed within 30 days. Ten others due in March 2014, April 2014, and May 2014 were listed as incomplete, though the reason for this was not clear. <u>Assessments Provided</u> Communication assessments for individuals in Samples R.1 (16 individuals) and R.4 (five individuals) were submitted as requested, with the exception of Individual #188. These were completed by a total of eight different SLPs, none of whom were employed at MSSLC at the time of this review. The following were submitted and current in the last 12 months: Comprehensive Communication Assessment 1. Individual #117 (10/23/13) 2. Individual #376 (5/9/13) 3. Individual #577 (8/1/13) 4. Individual #407 (7/16/13) 5. Individual #895 (10/1/13) 6. Individual #629 (1/3/14) 7. Individual #321 (9/29/13) 8. Individual #300 (9/19/13) Speech Pathology Baseline Assessment 9. Individual #784 (9/6/13) Speech Language/Communication Assessment of Current Status 10. Individual #80 (1/22/14) 11. Individual #441 (11/17/13) 12. Individual #43 (3/3/14) 13. Individual #300 (6/3/13) 14. Individual #320 (8/23/13) 15. Individual #197 (5/6/14) 16. Individual #503 (1/23/14)	

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		17. Individual #597 (18. Individual #395 (12/31/13) 19. Individual #432 (12/26/13) 20. Individual #524 (12/23/13) 21. Individual #888 (8/6/13) 22. Individual #188 (3/29/13) Additional current assessments were submitted, though three of the four clinicians for whom assessments were submitted were also were no longer employed at MSSLC and no assessments were submitted for one of the clinicians currently providing services (Lauren George): Comprehensive Communication Assessment 1. Individual #101 (3/31/14) 2. Individual #264 (2/19/14) 3. Individual #451 (1/23/14) 4. Individual #272 (2/25/14) Speech Language Pathology Screen 5. Individual #703 (1/17/14) Speech Language/Communication Assessment of Current Status 6. Individual #435 (1/3/14) 7. Individual #511 (1/5/14) 8. Individual #432 (12/26/13) 9. Individual #521 (1/16/14) 10. Individual #524 (12/23/13) 11. Individual #505 (2/27/14) 12. Individual #436 (2/3/14) 13. Individual #105 (11/23/13) 14. Individual #80 (1/22/14) 15. Individual #35 (3/4/14) 23. Individual #266 (2/20/14) 24. Individual #441 (11/17/13) 25. Individual #43 (3/3/14 • 20 of 21 individuals (95%) in Samples R.1 and R.4, who received direct and/or indirect communication supports and services, were provided an assessment or update current within the last 12 months. No current assessment was submitted for Individual #188, though she had communication needs warranting supports and services. This was an improvement from 85% in the previous review.	

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		• 27 of 35 individuals admitted since the last review in Sample R.2 (77%) received a communication assessment. Admission dates were not provided on the list included in section I of the document request, so it could not be determined if these were completed within 30 days of admission. Based on the admission dates listed in the communication assessment tracking log, however, it was noted that 24 of 27 assessments completed (89%) were within the 30-day timeframe. This was a decrease from 93% in the previous review. • For 12 of 21 individuals (57%) in Samples R.1 and R.4, the most current assessments or updates were dated as having been completed at least 10 working days prior to the annual ISP, or in the case of Individual #629, within 30 days of his admission to MSSLC. No assessments were submitted for Individual #188. The other eight were completed less than 10 days prior to the ISP with two of these completed after the ISP as identified on the assessment. This was a decrease from 82% in the previous review. • For 0 of 4 (0%) of individuals identified with communication needs through a screening, a comprehensive communication assessment was completed within 30 days of identification (Individual #614, Individual #554, Individual #225, Individual #437). Additionally, there were nine individuals newly admitted to MSSLC that did not receive either a screening or assessment so their communication needs were unknown. Because MSSLC requested a reduced review for this section, the monitoring team elected to select the one most current comprehensive assessment completed by each clinician. David Ehrenfeld, MSEd, CCC/SLP, was the only clinician for whom assessments were submitted who was providing communication services at MSSLC at the time of this review. The following assessments were included in the review below: 1. Individual #272 (2/25/14) 2. Individual #101 (3/31/14) 3. Individual #629 (1/3/14) The state and local MSSLC assessment format and content guidelines generally required that these elements be contained within the assessments. The comprehensiveness of the comprehensive communication assessments reviewed was as follows: • 3 of 3 assessments (100%) were signed and dated by the clinician upon completion of the written report. This was consistent with the previous review. • 0 of 3 assessments (0%) included diagnoses and relevance of impact on communication. This was a decrease from 100% in the previous review. • 3 of 3 assessments (100%) included individual preferences and strengths. This was an improvement from 83% in the previous review. • 0 of 3 assessments (0%) included medical history and relevance to	

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		communication. The medical history was reported, but with no analysis of the relevance to communication. This was a decrease from 17% in the previous review. • 1 of 3 assessments (33%) listed medications and discussed side effects relevant to communication. This was a decrease from 67% in the previous review. • 0 of 2 assessments (0%) provided documentation of how the individual's communication abilities impacted his/her risk levels. Risk areas were not adequately addressed and there was no discussion of the relationship to communication. This was a decrease from 100% in the previous review. • 2 of 3 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 consistent with the previous review. • 0 of 3 assessments (0%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was a decrease from 67% in the previous review. • 0 of 1 assessment (0%) 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 changes as required. A Communication Dictionary was not indicated for two of the three individuals (Individual #629 and Lee Individual #101). This was a decrease from 100% in the previous review. • 0 of 3 individuals' communication assessments (0%) included discussion of the expansion of the individuals' current abilities. This was a decrease from 67% in the previous review. • 0 of 3 individuals' communication assessments (0%) provided a discussion of the individual's potential to develop new communication skills. This was a decrease from 50% in the previous review. • 0 of 3 assessments (0%) included the effectiveness of current supports, including monitoring findings. This was a decrease from 40% in the previous review. • 0 of 3 assessments (0%) assessed AAC needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC. In the case of Individual #629, it was stated that exposure and experience to voice output devices may increase his interest in using one, but no recommendations were made for this either through direct or indirect means. In the case of Individual #272, it was reported that she had previously declined all offers for AAC devices, though there was no evidence that the clinician completed this comprehensive assessment made any attempt to assess this (2/25/14). In the case of Individual #101, the clinician stated merely that there were no devices, but did not provide any rationale for not assessing for one at the time of this	

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		assessment. Though this individual was verbal, a clear rationale should be provided in a comprehensive assessment as to why the individual would or would not benefit from AAC. This was a decrease from 33% in the previous review. • 0 of 3 assessments (0%) offered a comparative analysis of health and functional status from the previous year. This was a decrease from 40% in the previous review. • 1 of 2 assessments (50%) gave a comparative analysis of current communication function with previous assessments. Individual #629 was newly admitted to MSSLC so previous status was likely unknown. This was a decrease from 60% in the previous review. • 0 of 3 assessments (0%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was a decrease from 67% in the previous review. • 2 of 3 assessments (67%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. This was a decrease from 83% in the previous review. • 3 of 3 assessments (100%) had a reassessment schedule. This was consistent with the previous review. • 0 of 2 assessments (0%) supplied a monitoring schedule for individuals provided some level of supports and services. This was a decrease from 50% in the previous review. • O of 3 assessments (0%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, though each identified specific communication-related needs. This was a decrease from 50% in the previous review. • 3 of 3 assessments (100%) made a recommendation about community referral and transition, though the rationale was not provided. This was consistent with the previous review. • 0 of 3 assessments (0%) included specific recommendations for services and supports in the community. This was a decrease from 33% in the previous review. • 2 of 3 assessments (67%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was a decrease from 83% in the previous review. Additional findings related to the communication assessments were as follows: • There was a decrease across 18 elements. Improvements were noted for only one element, while the others remained consistent with the previous review at 100%.	

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		It was reported that a 10% sample of assessments (6 of 60) were audited for the identified elements. These findings were not consistent with the monitoring team's findings, with at least 15 elements present in each of six assessments audited. Updates or Assessments of Current Status (ACS) were submitted as most current for 11 individuals included in Samples R.1 and R.4. • 3 of 11 ACSs (18%) were completed consistent with the established schedule, the individuals' need, and/or previous recommendations, and the associated comprehensive assessment was present in the individual record (Individual #888, Individual #432, Individual #524). In the case of Individual #80, the most current assessment was identified as an Assessment of Current Status, with updates completed in the two previous years. It would be anticipated that she would have been provided a Comprehensive Assessment in 2014, though it was noted that the Assessment of Current Status was extensive and would have likely qualified as a comprehensive assessment. The Assessments of Current Status (the most current format for annual updates) included the following minimum requirements, given that a comprehensive assessment with the essential elements had previously been completed: • The individual's current status (10/11, 91%). • Description of the interventions that were provided (9/10, 90%). • Effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year (6/10, 60%). • Monitoring schedules (2 of 10, 20%). • Re-assessment schedules (10/11, 91%). Each of these was vastly different and of various formats with various content. This inconsistency was of concern to the monitoring team. <u>SLP and Behavioral health Collaboration:</u> There were 36 individuals identified with behavioral issues and co-existing severe (nonverbal or limited verbal skills). There were 49 individuals listed with PBSPs who also had replacement behaviors related to communication. At least six individuals in Sample R.1 were listed with a PBSP. Each of these was current and included in the individual records. Two others had medical restraint plans (Individual #395 and Individual #188, though these were not noted in the individuals records). Integration and collaboration between speech clinicians and psychology was absent per the self-assessment and the following findings of the monitoring team were	

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		consistent with that conclusion: • For 1 of 6 communication assessments (17%) in Sample R.1 for individuals with identified challenging behaviors, there was discussion of the communicative intent of those behaviors in the Behavioral Considerations section. • 0 of 6 communication assessments and PBSPs reviewed (0%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. • 3 of 6 communication assessment reviewed (50%) contained evidence of review of the PBSP by the SLP, though this was minimal. • For 0 of 6 individual (0%), communication strategies identified in the assessment were included in the PBSP, though there were no apparent inconsistencies for three of these. In the case of Individual #888, there were no recommendations for communication strategies offered in the communication assessment (8/6/14). In the case of Individual #629, there was a strategy that indicated that his demonstration of extreme emotion added to his message though may not always be the intended expression that he wanted to portray. This was an important distinction for staff interacting with him to understand in relation to his behavior and this was not addressed in his PBSP. In the case of Individual #197, his communication assessment listed that he was provided a communication board and environmental control units/switches (ECU). These were not actually discussed in the assessment dated 5/6/14, however. Neither of these devices was identified in his PBSP, though a number of the sensory activities identified as replacement activities could be accessed via ECU. Also there was no mention of his communication board in that plan. • For 0 of 6 individuals (0%), communication strategies related to behavior identified in the assessment were included in the ISP. Minutes for meetings held to review PBSPs during the last six months were submitted. • Based on review of the Behavior Therapy Committee (BTC) meeting sign-in sheets submitted, there was no evidence of participation by a SLP noted in any of the meetings (0%). This was consistent with the previous review when there was no SLP representation at meetings for review of PBSPs. Participation in the review of PBSPs during these meetings was only one opportunity to promote collaboration between behavioral health and the speech staff. There did not appear to be a significant effort to develop collaborative replacement behavior goals related to communication in any manner. 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. Continued effort is needed to ensure	

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		that there is sufficient coordination of supports, services, and communication methods. There may be other means to accomplish this beyond the PBSP meetings, such as the pre-ISP planning and during the assessment process. The communication assessment generally did not address communication with behavioral health related to the interpretation of the functions of target behaviors and whether there was a communication component and there was little evidence of collaboration between psychology and the SLPs. The facility self-rated this provision in noncompliance and the monitoring team concurred based on the findings reported above. Further coaching and monitoring of speech clinicians will be necessary to achieve compliance with the essential elements for communication assessments. There was no clinical leadership related to communication supports and services and this was evident in the lack of appropriate comprehensive content in the assessments and the lack of consistency across clinicians. In several cases, the assessments were written using similar or very near similar content and wording, significant redundancy, and/or the overuse of professional jargon. This should be avoided. As stated above there was no integration of communication supports and services with behavioral health services.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Integration of Communication in the ISP:</u> Attendance at the annual ISPs for individuals in Sample R.1 was reviewed. Signature sheets were submitted with the ISPs current within the last 12 months for each individual. Though his ISP was current, there was no signature sheet attached. Completed Pre-ISP required attendance sheets were not submitted for five individuals Individual #43, Individual #432, Individual #503, Individual #524, and Individual #441. • For 6 of 10 individuals in Samples R.1 (60%) for whom both a signature sheet and pre-ISP Required Attendance sheets were submitted, a SLP was in attendance at the ISP as designated by the pre-ISP. It was noted, however, that a SLP attended ISPs for 14 of 15 ISPs, per the signature sheets submitted. The pre-ISP process should generate documentation regarding which team members should attend the ISP. The decision for attendance should be based on the supports and services provided as well as based on individual needs. • For 11 of 21 individuals (52%), communication strategies identified in the assessment were included in the ISP. • In 19 of 21 ISPs for individuals with communication supports (90%), the type of AAC and/or other communication supports (e.g., Communication Dictionary, Communication Plan, and strategies for staff use) were identified. • Communication Dictionaries for those who had them (15) were reviewed at least annually by the IDT for 0%, as evidenced in the ISP. Most mentioned the	Noncompliance

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		dictionary as a support, but did not reflect IDT review. • 19 of 21 ISPs (90%) included a description of how the individual communicated, though some provided a very limited description. • 8 of 21 ISPs (38%) contained skill acquisition programs to promote communication. Most of these were identified by Education and Training only with no involvement by the SLP. In the case that direct communication therapy was recommended, there were no measurable goals listed in the ISP, but rather only that the individual would receive direct speech therapy. • Information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP was not addressed in the ISPs reviewed. The manner in which the IDTs addressed communication appeared improved since the previous review. Though there was evidence that the IDT discussed communication, none clearly outlined that the communication dictionary was reviewed and that modifications were or were not required. Most had an improved summary of how the individual communicated. How staff should communicate with them was noted in approximately half of the sample. <u>Individual-Specific AAC Systems:</u> By report, only eight individuals had been provided an AAC device. In many cases, it was reported that an individual refused to use a device during the assessment and, as such, it was determined that one was not warranted. There was no evidence that a concerted effort to promote opportunities for exposure in meaningful and functional contexts was attempted or directed by the SLP. The few systems provided were generally portable, functional, and individualized. There were 20 individuals listed as participating in direct communication therapy intervention at the time of this review largely for articulation and a handful with language goals. Only one of these (Individual #321) was listed with AAC. Communication dictionaries (CD) were also provided to many individuals and this appeared to be the primary communication support offered at MSSLC. The communication dictionary is not considered AAC, but rather a reference for staff to interpret common communication efforts by the individual. This should enhance staff understanding of the individual and promote consistent responses, but does not specifically improve the individual's expressive or receptive skills. Changes needed to the CDs were not specifically outlined in the ISP and there was little evidence that these had been reviewed for accuracy, at least on an annual basis, even in the communication assessment.	

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		The following metric could not be determined: • --% of individuals for whom the IDT directed a revision in the communication dictionary, the communication dictionary was revised within 30 days. Few of the assessments for the individuals in Sample R.1 and R.4 provided an adequate assessment of the individual's potential for AAC use. Many were based on observation made in a previous assessment and new attempts to introduce AAC in the assessments or on a structured trial basis were not noted in any case. 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, such as to request a favorite item, food, beverage, music, vibration, or massage. In some cases, the assessments reported that a device was tried, but when the individual did not spontaneously use it, the device was dismissed as a viable option. Specific efforts to promote practice and use in the natural environment should be identified for those individuals within the environmental communication efforts outlined above. This has been identified by the monitoring team in previous reviews. <u>General Use AAC Devices:</u> There were a few general use devices noted though none were seen in use. <u>Direct Communication Interventions:</u> There were only 20 individuals listed as participating in direct communication-related interventions provided by the SLP. Five of these were randomly selected for review by the monitoring team: Individual #300, Individual #321, Individual #895, Individual #784, and Individual #320. Records related to the provision of direct intervention for these individuals were reviewed (Sample R.4). This included assessments, ISPs, ISPAs, SAPs, and progress notes. Findings were as follow: • For 4 of 5 individuals (80%), 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. This was assumed to be the case as the intervention plans indicated that the implementation dates for Individual #784 and Individual #895 were within 30 days of the ISP, but progress notes were submitted only since December 2014. It appeared that direct therapy for Individual #320 was recommended in his communication assessment dated 8/23/13. By report, a communication assessment had not been indicated, but had been requested by the RNCM related to tongue thrust. Though this assessment was completed after the ISP on 7/30/13, the findings were included in the ISP document. The assessment was not an adequate Assessment of Current Status because it did not address his	

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		current status as to functional use of speech and language. The assessment focused only on his articulation disorder and direct therapy was recommended. The intervention plan used to document this intervention indicated that the implementation date had been 1/11/13. There was no evidence that the status of any previous intervention had been reviewed in the most current assessment. Measurable goals were not established in the assessment, but rather identified as "NA." The reassessment schedule was identified as one year to address progress in therapy. In the case of Individual #300, there was no evidence that recommended direct therapy per the assessment dated 9/19/13 had been implemented prior to 12/11/13. • For 5 of 5 individuals (100%), the current SLP assessment identified the need for direct intervention with rationale. • For 0 of 5 individuals (0%), there were measurable objectives related to individual functional communication outcomes included in the ISP. The identified SAP objective was not included as an action in the ISP for Individual #784. • For 5 of 5 individuals (100%), the therapist reported clinical data to substantiate progress and/or a lack of progress with the therapy goal(s). In the case of Individual #320, it was reported that he had not made progress, but there did not appear to be an effort to analyze the reason for this to make adjustments to the intervention, but rather only that if he continued to lack progress, therapy would be discontinued (5/4/14). • For 5 of 5 individuals (100%), there was a description of the benefit of the device and/or goal to the individual in the progress notes and/or monthly summaries. • For 5 of 5 individuals (100%), consistency of implementation was documented. • For 4 of 5 individuals (80%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress (Individual #320). • For 1 of 1 individuals (Individual #895) for whom direct intervention had been discontinued (NA), termination of the intervention was well justified and clearly documented in a timely manner. • 4 of 5 (80%) individuals (Individual #320) receiving direct Speech Services (Sample R.4) were provided with comprehensive progress notes that contained each of the generally accepted 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	

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		intervention plan as indicated related to the individual's progress or lack of progress. o Completed at least monthly. Data collection was addressed for each session. A monthly notation summarized overall progress for the month. <u>Indirect Communication Supports:</u> Indirect communication supports include PNMPs, communication plans, communication dictionaries, general use AAC, and communication-related SAPs. AAC supports were limited. There was no evidence of review of the Communication Dictionaries on at least an annual basis. Other indirect supports were developed by Education and Training in the form of SAPs implemented by DSPs in the home, day program, or work areas, though there appeared to be little to no collaboration by the SLPs. There were 49 individuals with replacement behaviors identified that were communication-based. Again, there appeared to be no integration between SLPs and behavioral health services. SLPs are also encouraged to work closely with the program developers on new or existing SAPs (not only those related to communication) to ensure that communication strategies are well integrated into these plans. The challenge moving forward is ensuring that these plans are implemented as intended and this requires real-time modeling and coaching. Effectiveness monitoring should be conducted by the SLPs related to these. See R.4 below. Individuals who received indirect communication supports (SAPs) should include the following elements: • Implementation within 30 days of the plan's creation (typically as of the ISP or ISPA), or sooner as required by the individual's health or safety. • The current SLP assessment should clearly identify the need for indirect intervention with rationale. This was more consistently noted for the assessments completed and reviewed. • Measurable objectives related to individual functional communication outcomes to be achieved through indirect intervention should be included in the ISP. • Staff instructions provided for individuals' AAC devices, including written step-by-step instructions and pictures. <u>Competency-Based Training and Performance Check-offs:</u> MSSLC had a system of competency-based training regarding communication services. The curriculum materials appeared to have been revised as of 4/11/14. The content material was presented in class as a PowerPoint and via instructor demonstration. There was no actual opportunity for participant practice and exploration, but rather the class	

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		moved immediately into the check-off components of the class. Habilitation Therapies provided new employees with classroom training on foundational communication-related skills. Based on the schedule submitted, class time included approximately two hours to address deaf awareness and AAC. This was significantly less than the time allowed for other PNM-related issues. Communication is an issue shared by all individuals and a key element to the successful provision of all supports provided by staff. As such, significant time is needed to provide instruction related to general communication and strategies of effective communication partners. The topics appeared to be basic related to AAC with limited time allotted for general communication strategies as only single topic slides were included in the PowerPoint, rather than content information. As described above, the two hour block was a very limited time to address communication effectively and comprehensively, with opportunities for hands-on exploration of AAC systems and practical experience with communication strategies. New employees were required to be checked-off on specific skills or answer questions related to the content presented, using a checklist. Return demonstration was required for each skill (approximately eight). The legitimacy of competency testing was likely limited given the timeframe permitted and the lack of actual practice time allowed for participants. Mentoring with PNMPCs was then conducted in the Martin and Barnett units prior to new employees being permitted to work independently on their assigned homes. They were required to answer a series of related questions to pass this portion of the training. The new staff were then assigned to shadow existing staff by the home charge. They did not work independently, but were allowed to assist existing staff in the implementation of foundational skills in that home for a few days and were not to be assigned to float to another home during the first month. Per policy, all staff were required to pass NEO core communication training (i.e., foundational skills), though the list of names completing this in the last six months was identified as an Active Employee Course Participation Report. It was not clear if these were existing employees for refresher training, or were new employees. There were 114 staff listed as participating in Alternate Means of Communication. Whether or not each had passed the competency testing was not identified. As this was not clear, the following metric was not applied: • % of staff who completed NEO core communication training (i.e., foundational skills) and passed performance check-offs since the last review, based on the participation reports. There was no established system to establish and maintain competency for staff who	

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		provided the training. Annual refresher training was not provided in the area of communication/AAC at the time of this review, though there was a plan to add this in the near future. <u>Individual-Specific Competency-Based Training</u> Non-foundational training was provided by Habilitation Therapy staff in the case that a required element of the individual's plan was not included as a core competency in the NEO/refresher training curriculum. This type of training required competency check-offs in order that staff could implement that element. There were no individuals identified with non-foundational components related to communication. The facility self-rated noncompliance with this provision and the monitoring team concurred. Though significantly improved, there was insufficient integration of communication supports and services into the ISP and very limited collaboration of SLPs with the design and implementation of communication-related SAPs, or with the manner in which communication strategies were integrated into other SAPs. 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 the information in the communication assessment related to the PBSP was well integrated. Ensure that the communication strategies are effectively translated into the PBSP and consistent with the individual's communication function and methods of communication. 2. Ensure that information related to communication was effectively translated to the ISP. 3. Ensure collaboration of SLPs in the integration of SAPs for individuals with communication deficits in need of specific strategies to enhance interactions with communication partners.	
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	<u>Compliance Monitoring of Implementation of Communication Supports</u> A system of compliance monitoring was not established at MSSLC for communication, outside of the effectiveness monitoring conducted by the SLPs or SLPAs. Previous compliance monitoring conducted by the PNMPCs had been suspended and not reinstituted at the time of this review. Methods to resume this were being considered by departmental leadership. The form used (Universal Monitoring Form for Communication Compliance and Effectiveness) was intended to address the following: • Plan was current and available. • Equipment was available. • Equipment was in good condition.	Noncompliance

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	their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	• Implementation as per the plan. • Staff communicated with the individual before and during activities. • Further staff drills were related to staff explaining the rationale of the communication plan, risks associated with not implementing the plan, and who to contact in the case that there was a problem. • Effectiveness of the plan. Completed forms for communication-related compliance monitoring conducted in the last three months were requested for the individuals in Sample R.1 with communication supports. Forms were submitted for Individual #80 (4/16/14 and 4/17/14), Individual #629 (4/9/14), and Individual #503 (1/21/14) only. There was no evidence that this was conducted on a routine basis (quarterly). There did not appear to be a system of compliance monitoring based on individual need or risk. Four forms for three individuals in Sample R.1 were submitted. Upon review of the forms submitted, the following was noted: • Though Individual #503's communication equipment was reported to be monitored, there was no mention of what that equipment was or how it was used. • In the cases of Individual #629 and Individual #80, compliance was listed as 90% though no indicators appeared to be marked "no," but rather "NA." This should have been calculated at 100% compliance. • In the case of Individual #80, the SLPA documented being present with the supervising SLP to complete compliance monitoring on 4/17/14. The SLP had also conducted compliance and effectiveness monitoring the day before on 4/16/14. There was no documentation of what the communication plan included. Additional compliance monitoring forms completed in the last month were submitted as requested. These included 13 forms for seven individuals (four forms for two individuals were duplicates of those described above for Individual #80 and Individual #629). Seven forms were related to compliance monitoring only and the others also included effectiveness monitoring further discussed below. Most of these addressed the Communication Dictionary on the notes page on the back of the compliance form. Compliance monitoring should be conducted routinely (i.e., quarterly) to address implementation of all specific communication plans (including AAC) and communication strategies across implementation of activities. This may be also accomplished as the staff are engaging in other activities on the PNMP or implementing other SAPs. Compliance monitoring appeared to be conducted, but not at any consistent frequency. Findings were clearly documented on the forms submitted as well as on an IPN, which should be	

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		reviewed for redundancy. Equipment should be monitored for availability, condition, and working order with routine general check-offs for how to use the equipment. This aspect may require additional monitoring to track the working condition of individual and general user devices on at least a monthly basis. Communication dictionaries should be monitored for availability, effectiveness, and whether staff understand how to use them, at least quarterly. <u>Effectiveness Monitoring</u> 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 health and functional status of the individual since the previous review, staff compliance, and whether the supports and/or strategies effectively met the intended need. Frequency of these should be included in the ISP with documentation in the individual record. Documentation 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, consistency of implementation • 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 At MSSLC, the Universal Monitoring Form for Communication Compliance and Effectiveness was used for effectiveness monitoring and paired with compliance monitoring. Effectiveness monitoring completed for the last six months was requested for individuals in Sample R.1. Effectiveness monitoring forms were submitted for only three individuals as described above. If this had been completed on a quarterly basis, there should have been at least one, if not two, for each individual with communication supports. Clearly there was a significant lack of consistency related to the completion of these for individuals who were provided communication supports and there was a lack of	

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		reference to these findings in the communication assessments reviewed. 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. Establish a system to ensure that staff are monitored routinely to carry out communication plans and provide supports. There is currently no method for staff to participate in annual training so monitoring and the provision of routine coaching is critical. 2. Establish clear procedural guidelines for effectiveness monitoring and include documentation guidelines to enhance consistency. Review use of the IPNs and consider guidelines to ensure that all elements described above are included. 3. Track findings of both effectiveness and compliance monitoring. Audit for timely completion of each as per the recommendations in the assessment or other established guidelines. Ensure that these findings are included in annual communication assessments for individuals and that the recommended interval for review was clearly outlined.	

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 #120, Individual #143, Individual #195, Individual #233, Individual #659, Individual #816, Individual #451, Individual #98, Individual #211, Individual #989, Individual #752, Individual #761, Individual #8, Individual #597 o Skill Acquisition Plans (SAPs) for: • Individual #752, Individual #233, Individual #761, Individual #8, Individual #597, Individual #10, Individual #835, Individual #702, Individual #291, Individual #501 o Monthly review of SAP progress for: • Individual #752, Individual #233, Individual #761, Individual #8, Individual #597 o Functional Skills Assessment (FSA) for: • Individual #752, Individual #233, Individual #761, Individual #8, Individual #597 o Preference & Strengths Inventory (PSI) for: • Individual #752, Individual #233, Individual #761, Individual #8, Individual #597 o Vocational assessments for: • Individual #752, Individual #8, Individual #597, Individual #761, Individual #233 o Self-administration of medication skills assessment for: • Individual #752, Individual #761 o Section S Presentation Book, June 2014 o Section S action Plan, 4/24/14 o Section S self-assessment 5/9/14 o A summary of community outings per residence for the past six months o A summary of all SAP treatment integrity checks for the past six months o Desensitization plans status report, 6/3/14 o Desensitization Committee Agenda, 5/15/14 o Skill Acquisition Plan Integrity Check, 4/1/14 o Expectations per home for community outings and training, undated o A list of all community outings, 10/13- 3/14 o A list of all instances of skill training provided in the community, 10/13- 3/14 o A list of all training conducted on skill acquisition programming, 10/13-3/14 o A list of individuals employed on-and off campus, undated o Description of on-and off-campus work programs, undated o A list of training conducted on skill acquisition plans, undated o List of all individuals under age 22 and their current public school placement o ISP, ARDIEP, MISD progress reports, MISD discipline referrals, MSSLC ISPAs, MSSLC ISP monthly

	reviews Individual #554, Individual #106, Individual #835 <u>Interviews and Meetings Held</u>: o Barbara Shamblin, Director of Education and Training; Janet Jacobs, Education and Training Program Compliance Monitor; Sarah Ham, STEP Center Director o Norvell Starling, MSSLC liaison to MISD <u>Observations Conducted</u>: o Desensitization Committee meeting o SARC meeting o Skill acquisition plan treatment integrity session for: • Individual #104, Individual #192 o Longhorn morning unit meeting, 6/5/14 o Pre-ISP for Individual #539 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 education and training 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 education and training department in completing the self-assessment, and believes that the facility continued to proceed in the right direction. MSSLC's self-assessment indicated that all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facilities findings.
	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: • Improvement in the quality of SAPs (S1) • Addition of SAM/HIP to the new SAP format (S1)

	• Improvements in overall individual engagement (S1) • Establishment of individualized day treatment engagement goals (S1) • Increased percentage of SAPs reviewed that were clearly based on assessment results (S2) • Establishment of SAP integrity goals (S3) • Establishment of goals for community outings and training (S3) The monitoring team suggests that the facility focus on the following over the next six months: • Ensure that SAP training instructions are clear and tailored to individual needs (S1) • Expand the SAP training methodologies used (S1) • Demonstrate that established day and residential individual engagement goals are achieved (S1) • Ensure that PSIs, FSAs, and vocational assessments are completed and available to team members at least 10 days prior to each individual's ISP (S2) • Ensure the documentation of how the results of assessments of preference, strengths, skills, and needs impacted the selection of all skill acquisition plans (S2) • Ensure that SAP graphs measure behavior that clearly reflects progress toward learning objectives (S3) • Modify the SAP integrity scoring to ensure that it adequately assesses if staff are implementing SAPs as written (S3) • Ensure that established SAP integrity goals are achieved (S3) • Ensure that established community outing and SAP training goals are achieved (S3)

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item includes an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at MSSLC. Overall, there was been progress in the quality of the SAPs and individual engagement since the last review. This item was rated in noncompliance, however, because more work is needed in individualizing SAP training instructions and training methodologies to maximize individual learning. <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 six 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,	Noncompliance

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		development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. MSSLC recently developed a new SAP format that included the necessary components. Since the last review, the facility added the SAM and HIP programs to the new SAP format. At the time of the onsite review, the majority of all SAP programs at MSSLC were in the new format. At this point, it is recommended that the facility ensure the last few SAPs in the old format are converted to the new improved format. To assist compliance with this provision, the monitoring team reviewed 35 SAPs across 10 individuals. Three of those SAPs were in the old format and, therefore, were not used in the evaluation of this provision item. In 28 of the 33 new format SAPs reviewed (85%), the rationale appeared to be based on a clear need and/or preference. This represented a dramatic improvement from the last review when 70% of the SAPs appeared practical and functional. An example of a rationale that appeared to be based on a clear need and/or preference was: • The rationale for individual #752's reading SAP indicated that he wanted to live and work in the community, and needed to improve his reading to fill out a job application 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 #233's math SAP stated he could not do four digit multiplication. 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. 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	

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		• Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology The new SAP format contained all of the above components. As found in the last review, all 33 (100%) of the SAPs reviewed had complete maintenance and generalization plans, specific consequences for both correct and incorrect responses, and relevant discriminative stimuli. The only component that was judged to not be consistently complete was training instructions. Although all SAPs reviewed contained training instructions, there were some general problems in the description of the teaching method or behaviors. The majority of SAPs reviewed (SAM/HIP were the exception) included an identical training procedure which specified that training occur on the first step of the task that the individual had yet to master, and that he/she be guided through the remaining steps of the task using least to most assistance (i.e., whole task training). It is likely, however, that for some tasks and/or individuals, training just one step would be more effective. For example, Individual #752's addition SAP consisted of two steps: add two digits by one digit with no carrying (e.g., 71+5), and add two digits by one digit with carrying (e.g., 79+5). Prompting him through step two before he mastered step one may be confusing and slow his progress with step two. In this case, it may be most efficient to have him master adding without carrying before he is exposed to adding with carrying. Additionally, the specific prompt levels were not consistently included in the training instructions. Including the specific training prompts is important because it is likely that some prompts with some individuals (e.g., hand-over-hand guidance) could lead to behavioral issues that would interfere with learning. At the time of the onsite review, the facility exclusively used forward chaining training methodologies. As discussed above and in S3a, it is recommended that MSSLC expand and individualize the training methodologies (e.g., backward chaining, training on single steps, etc.) to maximize learning. Overall, the quality of the SAPs improved since the last review. The monitoring team believes that these recent improvements are due, at least in part, to the practical and functional Skill Acquisition Review Committee (SARC) meetings that the facility conducted. 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	

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		quality of the reviews, and encourages the facility to continue to conduct these meetings. It is recommended, however, that the SARC meetings closely review the training procedures and methodologies to ensure that they are maximize each individual's acquisition of the SAP. <u>Dental compliance and desensitization plans</u> As discussed in the last review, compliance and desensitization plans (both formal and informal) were designed by the behavioral health services department to teach individuals to comply with routine dental procedures. The behavioral health services department continued to assess if refusals to participate in dental exams were primarily due to general noncompliance, or due to fear of dental procedures. The interdisciplinary team that reviewed these plans and other interventions to decrease the use of 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. Data presented at this meeting indicated that dentistry and behavioral health services were working cooperatively to minimize the use of sedation for routine dental examinations. A list of dental desensitization plans developed indicated that no plans were developed since the last onsite review. <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 two of the 10 individuals reviewed (20%) had skill acquisition programs targeting the enhancement or establishment of communication and language skills. This represented an improvement from 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 continue to expand the number of communication SAPs for individuals with communication needs. <u>Engagement in Activities</u> As a measure of the quality of individuals' lives at MSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals at the facility was measured by the monitoring team in	

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		multiple locations, and across multiple days and times of the day. Engagement was measured by 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, participating in sporting events, 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. As reported in past reviews, the monitoring team found many individuals out of the homes, engaged in appropriate outside activities on campus, and in the community. The majority of individuals in the residences appeared to be engaged in typical activities, such as doing homework, playing games, listening to music, talking to friends, watching television, or socially interacting with staff. Since the last review, MSSLC had been working on improving the quality and engagement of the day programs. The monitoring team observed several examples of new day programs that appeared to provide more meaningful activities and opportunities to learn functional skills (e.g., life skills programs). Despite these overall improvements in individual engagement discussed above, some areas (e.g., the Martin day program) appeared to need improvement in meaningful programming and individual engagement. The monitoring team's average engagement score across the facility was 66%, an increase from the last two reviews that had an average 62% engagement score. The facility continued to conduct its own engagement assessments. Since the last review MSSLC modified the method they used to collect engagement. The facility now used a momentary time sample similar to that used by the monitoring team to assess individual engagement. The facility's average engagement for January 2014, February 2014, and March 2014 averaged 79%, which represented a substantial improvement from the last review when the facility's average engagement score was 61%. Finally, MSSLC recently established individual engagement goals for each residential unit and day program site. From January 2014 to March 2014 three (Martin, Longhorn, and Whiterock) of the five residential units, achieved the facility's engagement scores. At the time of the onsite review, however, not all day treatment sites had engagement data for January 2014 to March 2014. The monitoring team is encouraged by these improvements in engagement at MSSLC. At this point, it is recommended that the facility ensure that engagement targets for day program and residential treatment sites are achieved.	

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Engagement Observations:

Location	Engaged	Staff-to-individual ratio
S2	3/5	2:5
S2	4/5	2:5
S1	2/3	1:3
B3	5/7	2:7
B7 and B8 common area	1/4	1:4
Rockin Robin Cafe	15/15	4:15
Life skills	1/1	2:1
Life Skills	2/2	1:2
Life Skills	3/3	2:3
Large Workshop	16/17	5:17
Greenhouse	3/3	2:3
Step Center	3/4	2:4
Life Skills	4/4	3:4
Life Skills	1/2	1:2
Life Skills	2/6	1:6
Step Center	2/3	2:3
Step Center	2/3	2:3
Step Center	3/3	2:3
Martin day program	2/5	2:5
L1	5/6	3:6
L5	2/2	2:2
L6	0/3	1:3
W5	0/3	1:3
W7	1/4	1:4
Martin day program	2/8	4:8

Educational Services

The monitoring team again reviewed the ISD services provided to individuals at MSSLC who were entitled to educational services. Approximately 75 students received educational services from Mexia Independent School District (MISD) across this past school year, with 66 at the time of this onsite review. This compared to 61, 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 (57), but others were at the regular high school (9). At this time, none attended the regular junior high school or elementary school. Most of the students lived in the Longhorn unit (47). Those students who were older than 18 years old lived at Whiterock (2), Shamrock (6), and Barnett (2).

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		The positive relationship between MSSLC and MISD continued, much to the benefit of the students. The unit directors reported that the past school year was one of the best in many years. Norvell Starling continued as the MSSLC liaison to MISD. He was in this position for more than six years and had a very good relationship with MISD as well as with the unit directors and other MSSLC staff. He attended the Longhorn unit morning meeting almost every day and he attended some ISP meetings. Some of the key administrators and other staff at MISD were scheduled for retirement. Mr. Starling was invited by the school district to participate in the choosing of the new administrators and staff. This demonstrated the strong relationship between the facility and ISD. Almost every student eligible for graduation took graduation and received a diploma. This was wonderful to see. Moreover, there were very few student refusals to attend school each day. The student's school programs were described in the MSSLC ISPs in the narrative and in action plans to support what was being taught at school. MSSLC was also noted in every student's ARDIEP. Further, Mr. Starling attended every ARDIEP, as evidenced by his signature on the ARDIEP attendance pages. Sometimes other MSSLC staff attended, most frequently the behavioral health specialist. MSSLC QIDPs and IDTs reviewed MISD progress reports, report cards, and discipline referrals. This was documented in ISPAs and in the QIDP's monthly review of the entire ISP. Student's school programs were discussed at ISP and pre-ISP meetings. For example, at the pre-ISP meeting for Individual #539, the education and training department spoke about ensuring that the ISP includes what he worked on at school. There was team discussion (including the individual and his mother) about improving his reading and including a reading improvement SAP. At the Longhorn morning unit meeting, the group reviewed any MISD issues, such as attendance refusals and behavior problems. MISD data were part of the section S monthly PET report and the quarterly QA report and QAQI Council presentations.	

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		The monitoring team has no further recommendations for this aspect of section S related to substantial compliance. To continue to improve quality related to supporting the educational services received by students at MSSLC, the monitoring team suggests the following: • Continue to collect data on educational services related areas and include these data in the facility's section S QA program. • The few attendance refusals that occurred for the students who were older than 18 years old (and therefore lived on Barnett, Shamrock, or Whiterock units with other adults). The facility should focus on this small number of students to ensure that their progress towards a high school diploma does not get disrupted. • It appeared that once students transitioned to the regular high school, there were few opportunities for inclusive educational experiences. For the most part, they spent their school day in a special education classroom. Thus, in some ways, they had a more varied and typical school day at the special education building where they changed classrooms and teachers each period. Mr. Starling said that he was going to be working with the new school district administrators next year with a goal of much more inclusion into the typical high school population. The monitoring team agrees with this.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	MSSLC conducted annual assessments of preference, strengths, skills, and needs. This item was rated to be in noncompliance, however, because only 59% of SAPs reviewed were clearly based on assessments, and there was no documentation that preference and strength inventories were consistently available to team members at least 10 days prior to each individual's team meeting. 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. All individuals had FSAs, PSIs, and vocational assessments. This was an improvement from the last review when two individuals reviewed did not have a PSI. 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 80% of FSAs and 76% of vocational assessments were competed 10 days prior to the ISP. This was a decrease from the last review when 85% of FSAs and 88% of vocational assessments were competed 10 days prior to the ISP. PSI tracking data were not available at the time of the onsite review. It is recommended that the facility ensure that FSAs, PSIs, and vocational assessments are consistently available to team members at least 10 days prior to the ISP.	Noncompliance

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		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 27 SAPs, and 16 of those (59%) had documentation that assessments were used to develop them. This represented an improvement from the last review when 52% of the SAPs reviewed included documentation that assessments were used to develop them. Examples of assessments that were used to develop SAPs included: • Individual #761's reading SAP was based on his PSI that indicated that he wanted to improve his reading, and his FSA that indicated he was not an independent reader. • Individual #597's FSA and ISP documented her communication need. Based on that need, a specific communication SAP was developed. Examples of SAPs where it was not clear how or if assessments impacted their development included: • Individual #233 had a SAP to learn to fill out an application, however, his vocational assessment stated that he was independent in filling out job applications. • Individual #8 had a SAP to improve his communication skills, however, his FSA indicated that he used communication devices to independently communicate his needs and wants.	

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		In order to achieve substantial compliance for this provision item, MSSLC needs to ensure that at least 85% of 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 that at least 85% of SAPs reviewed were clearly based on assessment results.	
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. Eighteen of the 27 SAPs reviewed had at least three months of data. Eleven of those 18 SAPs (61%) indicated SAP progress. This represented an increase from the last review when 56% 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 #752's community objective SAP, Individual #8's SAP to learn to pick up his clothes). All of the SAPs reviewed had graphs. The usefulness of some of the graphs was limited, however, because it was not clear what was measured or how it was related to SAP learning objective. For example, Individual #752's graphs were percentages, but it was not clear what they measured (e.g., steps completed, prompt level, etc.). Some dependent measures to graph that could help to reflect progress are steps completed at the goal prompt level (e.g., independent), or the prompt level needed to accomplish goal. It is recommended that all graphs measure behavior that clearly reflects progress toward leaning objectives. The implementation of SAPs was observed by the monitoring team to evaluate if they were implemented as written. Both of the SAPs observed (Individual #296's SAP to use a vibrating device, and Individual #192's reading SAP), did not appear to be implemented as written. The behavioral objective in Individual #296's SAP stated that she should	Noncompliance

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		independently use the vibration device. The education and training instructor that implemented that SAP, however, physically guided Individual #296 through the use of the device and recorded it as independent. Individual #192's SAP indicated that he should be trained on the first step that he was not independent, and that staff should complete the remaining steps for the individual, using least to most assistance. Individual #192's education and training instructor, however, trained on all the steps of the task analysis. Although training all steps may be the most effective training procedure for some individuals, it is critical that all staff conduct the training sessions identically so as to maximize learning. MSSLC conducted their own SAP integrity. From January 2014-March 2014 SAP integrity averaged 91%, which was an improvement over the last review when 83% of SAPs were reported to be implemented with integrity. The SAP integrity assessment consisted of a direct observation of staff conducting SAPs and nine questions concerning the training, such as "did the training occur as scheduled?" and "is the SAP being implemented as written?" It is not completely clear why the monitoring team and the facility's integrity measures were so disparate. One possible reason, however, is how the facility scored SAP integrity. At the time of the onsite review, the scorers weighted each of the nine questions equally, and divided the number of items scored as correct over the total nine items to arrive at an integrity score. It may be the case, however, that some items better reflect SAP integrity (e.g., did the individual implement the SAP as written) than others (e.g., did the training occur on schedule). For example, it would be possible that Individual #192's SAP integrity score would be 90%, even though that SAP was not implemented as written. It is recommended that MSSLC modify the weights of each item in their integrity tool (i.e., score such that some items affect the integrity score more than others), so that "implementing the SAP as written" is greater reflected in the integrity score. Over the next six months, it is recommended that MSSLC ensure that SAP graphs measure behavior that clearly reflects progress toward leaning objectives, and that SAP integrity scores adequately assesses if staff are implementing SAPs as written.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at MSSLC enjoyed recreational and training activities in the community. Since the last review, the facility established individualized community outing and community training goals for each home. At this point, it is recommended that that MSSLC document that 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	Noncompliance

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		during the last onsite review. In order to achieve substantial compliance with this provision item, the facility needs to document that the minimal frequencies of recreational activities and community SAP training per home are consistently achieved.	

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: ○ Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.2, 10/18/13, and exhibits and forms attachments • State office guidance documents regarding special review process (November 2013) and potentially disrupted community transitions (December 2013) ○ MSSLC facility-specific policies regarding most integrated setting practices • All Admissions/Placement department policies remained the same and were not re-reviewed. ○ MSSLC organizational chart, 5/12/14 ○ MSSLC policy lists, May 2014 ○ List of typical meetings that occurred at MSSLC, undated but likely May 2014 ○ MSSLC Self-Assessment, 5/9/14 ○ MSSLC Action Plans, 5/9/14 ○ MSSLC Provision Action Information, 3/31/14 ○ MSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book ○ Presentation materials from opening remarks made to the monitoring team, 6/2/14 ○ Community Placement Report, last six+ months, 12/1/13 through 5/30/14 ○ List of individuals who were placed since last onsite review (31 individuals) ○ List of individuals who were referred for placement since the last review (58 individuals) ○ List of individuals who were referred and placed since the last review (7 individuals) ○ List of total active referrals (65 individuals) ○ List of individuals who requested placement, but weren't referred (46 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 (0) ○ List of individuals who were not referred solely due to LAR preference (29 individuals) ○ List of rescinded referrals (13 individuals) • ISPA notes regarding each rescinding (10) • Special Review ISPA Team minutes for each rescinding (6) ○ List of individuals returned to facility after community placement (1 individual) • Related ISPA documentation (1) • Special Review ISPA Team minutes (1) • Root cause analysis (0) ○ 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

	• 13 of 56 individuals who moved since 5/1/13, data as of 5/12/14 o Completed Potentially Disrupted Community Transition forms (13) 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 (15 individuals, through 5/5/14) o APC reports • APC Department meeting minutes (February 3, March 1, April 1, May 1) • APC weekly reports, version for state office only, 4/25/14-5/2/14 (4) o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair • Community tours • Work with local LA • Work with local providers • Facility-wide staff trainings/activities • For individuals • For families o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the result of the facility's assessment for community placement (i.e., whether or not they were referred) o Example of a living options discussion ISPA, 11/1/13 o APC tracking sheet of all active referral activities, updated 6/6/14 o List of individuals who had a CLDP completed since last review (34) o Blank assessment checklist tool used by APC o Examples of MSSLC training for discharge assessments (2) o Examples of MSSLC training of community provider staff (1) o Example of a day of move receipt verification (1) o QA related activities and documents • QA reports for last six months (2, January 2014, April 2014) • Set of graphs of APD activities • Email regarding root cause analysis training, 4/16/14 o State obstacles report and SSLC addendum, March 2014 o MSSLC obstacles graph and database, 5/8/14 o PMM tracking sheet, 6/6/14 o Transition T4 materials for: • Individual #750, Individual #693, Individual #934, Individual #367, Individual #696 o ISPs for: • Individual #535, Individual #211, Individual #261, Individual #386, Individual #80, Individual #521, Individual #816, Individual #884 o Draft ISP used during the ISP meeting: • none

	○ CLDPs for: • Individual #502, Individual #504, Individual #429, Individual #313, Individual #70, Individual #153, Individual #593, Individual #373, Individual #754, Individual #125, Individual #309, Individual #347 ○ Draft CLDP for: • Individual #455 ○ 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 #2: P, 7, 45, 90 • Individual #927: P, 7, 45, 90 • Individual #700: P, 7, 45, 90 • Individual #236: P, 7, 45, 90 • Individual #313: P, 7, 45 • Individual #569: P, 7, 45 (45 with monitoring team) • Individual #504: P, 7, 45 • Individual #593: P, 7, 45 • Individual #125: P, 7, 45 • Individual #153: P, 7, 45 • Individual #502: P, 7, 45 <u>Interviews and Meetings Held</u>: ○ Jeanette Reaves, Admissions and Placement Coordinator ○ Pamela Gonner, Post Move Monitor ○ Group home and day program staff and managers at Cen-Tex, Mexia, TX <u>Observations Conducted</u>: ○ CLDP meeting for: • Individual #455 ○ ISP and pre-ISP meetings for: • Individual #519, Individual #539 ○ Living options discussion meeting for: • none ○ Community group home and day program visit for post move monitoring for: • Individual #569
	Facility Self-Assessment Given that a new APC was recently appointed, the self-assessment was not updated to be a useful review of the facility's status in section T. The self-assessment was somewhat improved from the previous self-assessment in that there were a few more items were similar to how the monitoring team determines

	substantial compliance. Overall, however, the self-assessment should, but did not, fully line up with the content of the monitoring team's report. The monitoring report now contains metrics within each provision. Each metric is preceded by a letter. The APC should use these to develop her next version of the self-assessment. For this review, the APC self-rated the following eight provisions to be in substantial compliance: T1b, T1c, T1c2, T1c3, T1d, T1h, T2a, and T4. The monitoring team agreed with four these self-ratings (T1c2, T1c3, T1h, T2a). In addition, the monitoring team rated T2b in substantial compliance. The reasons for the differences in ratings are evident in the following review, but were primarily due to the self-assessment not looking all of the aspects of the provision that were looked at by the monitoring team, such as documentation of initiation of the CLDP (T1c), content/quality of the discharge summaries (T1d), and date of completion of the alternative discharge reports (T4).
	Summary of Monitor's Assessment There were again staffing and leadership changes in the admissions and placement department, including a new APC. The number of individuals placed was at an annual rate of about 21%, an increase since the last review. 31 individuals were placed in the community since the last onsite review. 58 individuals were referred for placement since the last onsite review, the most in any six-month period to date. 65 individuals were on the active referral list. Placements were slowed by the absence of providers who could meet the physical and accessibility needs of individuals, and the absence of providers willing and capable of supporting individuals with complex behavioral and psychiatric histories who also were alleged offenders. Of a sample of 5 ISPs, 2 (40%) included an adequate list of obstacles to referral. One of the 5 (20%) had a list of activities that was individualized and specified what will be done over the upcoming year regarding exploring community living options. Of a sample of 8 ISPs, all of the written assessments for 0 individuals (0%) included an applicable statement or recommendation from all disciplines regarding referral to the community. However, during the actual ISP meeting, professionals gave their opinions. Even so, thorough discussions of living options were not conducted for most individuals. CLDPs in the sample reviewed were not initiated within 14 days of referral, and 50% showed updates and ongoing activity in the months following referral. When activity did occur, IDT members were very much involved in all cases. Discharge assessments were written by all of the required disciplines. The assessments, however, did not address the individual's new home, day program, or employment settings and how supports might need to be provided in a different manner in these new settings.

	CLDPs did not clearly identify a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition by including documentation to show that adequate training of community provider staff occurred and that there was sufficient collaboration with the new provider. The CLDPs list of pre and post move supports were not comprehensive. That is, they did not address all of the areas that needed to be addressed for the individual's unique needs, especially regarding behavioral, psychiatric, and crisis interventions. A QA program for CLDPs and section T did not exist. The APC, however, was collecting and trending a variety of data. The facility obtained substantial compliance with T2a and maintained substantial compliance with T2b. Post move monitoring was done thoroughly, on time, and in all settings. Discharge summaries for alternative discharges (T4) were not prepared prior to the individual's move.

#	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	<u>Placement Department Staff</u> There were again staffing and leadership changes in the admissions and placement department (APD). Jeanette Reaves was appointed as Admissions and Placement Coordinator (APC) to lead the department. She began her new role in mid-March 2014 after completing NEO, thus, she had been in the position for a relatively short time. As a result, the six-month period for this compliance review also covers the work of Sarah Ham, who was acting as APC in an interim role until the APC position was permanently filled. Fortunately, Ms. Reaves worked at MSSLC for a number of years in the APD, including as post move monitor (PMM). In the time since then, she worked as a HCS community program certification and waiver specialists for DADS. Thus, her experience as PMM and as a HCS surveyor provided her with a great deal of experience and a broad range of knowledge of the community system, providers, problems, and successes. The APD was now fully staffed, though some were completing NEO and others were still in need of training at the time of this review. The department consisted of a PMM, three placement coordinators, three state transition specialists, and an administrative assistant. Given this team of eight full time staff, much progress should be possible by the time of the next review. <u>Transition-Related Numbers</u> Transitions: • The number of individuals placed was at an annual rate of about 21%, an	Noncompliance

	developmental disabilities.	increase since the last review. 31 individuals were placed in the community since the last onsite review. This compared with 29, 33, 28, 17, 25, 23, and 63 individuals who had been placed at the time of the previous monitoring reviews. Referrals: • 58 individuals were referred for placement since the last onsite review, the most in any six-month period to date. This compared with 36, 40, 37, 21, 27, 18, and 44 individuals who were newly referred at the time of the previous reviews. o 7 of the 58 individuals were referred and placed since the last review. This compared with 2 at the time of the last review. • 65 individuals were on the active referral list. This compared with 53, 52, 50, 42, 49, and 73 individuals at the time of the previous reviews. o 12 of the 65 individuals were referred for more than 180 days. This compared to 17, 28, 14, and 26 at the time of previous reviews. o 4 of these 12 individuals were referred for more than one year. This compared to 10, 2, 3, and 5 at the time of previous reviews. The facility maintained a higher number of referrals than ever before, however, the number of individuals who were referred for more than 180 days or for more than one year had decreased. <u>Determinations of professionals</u> Professional members of the IDT are required to state their opinion regarding the most integrated setting for each individual in their annual assessments, during the ISP meeting, and in the written ISP document. Compliance is addressed in T1b3. <u>Placement and referral not opposed</u> a. In reviewing the CLDPs 12 CLDPs of individuals who had been placed and 8 ISPs of individuals, some of whom were on the referral list and some of whom were not, 20 (100%) individuals and/or LARs did not oppose transition to the community. <u>Responding to individual requests and rescinded referrals</u> There were 13 rescinded referrals since the last review. This compared to 12, 9, 1, 7, and 20 at the time of previous reviews. Documentation (ISPA notes, ISPs, or SRT) was provided for 10 of the 13 individuals regarding the reasons for the rescinding, however, 3 had occurred in the previous few weeks and documentation was not yet completed. Therefore, the monitoring team considered 10 of 10 (100%) to have documentation. Of these, ISPA notes were present for 10 of 10 (100%), but special review team meetings occurred for only 6 of the 10 (60%). 1 of the 3 for which there was no documentation was an individual who ran away from the facility and was recently located incarcerated in another state. His rescinding occurred during the week of the onsite review (Individual #350).	

		b. Of these 10, the reasons for the rescinding appeared to be reasonable for 8 (80%). • One was rescinded because a provider could not be found (Individual #161) and one was rescinded because the individual was indecisive (Individual #150). • 6 were rescinded for serious behavioral and/or psychiatric problems, including one individual who was aggressive during a trial visit to a community provider and was arrested and jailed. • 2 were rescinded because the individual and the IDT determined that the stipulations and restrictions in their court orders would have been almost impossible to comply with in a community setting. An adequate review to determine if changes in the referral and transition planning processes at the facility was conducted for 1 (10%) of the rescinded referrals. This was for Individual #464. The facility stated that, prior to referral, the facility needed to ensure that the IDT and individual understood the conditions of any court order and how the court order would impact the individual's life in the community. Of these reviews, actions were recommended in 0 (0%) cases. Of these, actions were implemented for n.a. (n.a.%). This was documented in the special review team minutes. These discussions could also be documented in a clearly identified portion of another existing document, such as within weekly APD meeting minutes. The rescinding of a referral should not be considered a failure and should not deter IDTs from referring individuals. A review for quality improvement purposes, however, should be conducted for all. c. 46 individuals were described as having requested placement, but were not referred. This compared with 168, 107, 85, 157, 160, 168, and 40 individuals at the time of the previous reviews. Of the 46 individuals who requested placement, but were not referred, 0 individuals had an LAR who made this decision. Of the remaining 46 individuals, an appropriate review, appeal, and or lack of consensus review was conducted for 0 (0%). • The absence of a review or appeal for these individuals was noted in previous monitoring reports and should be attended to by the facility. Given the large number at MSSLC, a coordinated effort is likely to be needed. • The monitoring team could not determine why the number was lower than ever before. This data set should be examined for accuracy. The list of individuals not being referred solely due to LAR preference contained 29 names. It was not clear, however, if this list was accurate, that is, whether LAR preference was indeed the sole reason for no referral or if LAR preference was one of a number of reasons for no referral. This compared to 68, 100 and 1 individuals at the	

		time of the previous reviews. <u>Systemic issues</u> d. There were no systemic issues delaying referrals (at the state and/or facility level). e. There were existing and/or potential systemic issues delaying transitions (at the state and/or facility level). These were: • the absence of providers who could meet the physical and accessibility needs of individuals. In one case, the facility rescinded the referral. • the absence of providers willing and capable of supporting individuals with complex behavioral and psychiatric histories who also were alleged offenders. • conditions of the court orders restricting activities of specific individuals. At least two referrals were rescinded due to this. f. Funding availability was cited as a barrier to one individual (Individual #629) moving to the community. g. Senior management at the facility was not kept informed of the status of referral, transition, and placement statuses of all individuals on the active referral list. • The APC sent a spreadsheet once each month to executive management committee. This was only a group of about six senior managers. The vast majority of directors and senior clinicians were not kept informed either via email or oral presentation. <u>Pace of transitions</u> h. Transitions were not occurring at a reasonable pace. To make this determination, the monitoring team reviewed CLDPs, ISPs, ISPAs, 180 day meeting notes, any APD meeting minutes or reports, the APC's weekly enrollment report sent to state office, and various emails and meeting minutes. 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 sample of 12 individuals placed since the time of the last onsite review, 8 (67%) were placed within 180 days of their referral (i.e., 4 were not). o 2 of the 4 were placed after more than one year of being referred. • At the time of the review, 65 individuals had been referred for community transition. 53 of these 65 (72%) had not exceeded the 180-day timeframe	

		(i.e., 12 had exceeded 180 days). o Of the 12, 4 individuals had exceeded one year. Three of the individuals who were placed after more than 180 days, and 6 of the individuals on the referral list for more than 180 days were chosen for metrics .i., j., and k. That is a total of 9 individuals. i. Reasonable activity and actions had occurred related to the transition and placement for 0 of the 9 (0%) individuals. IDTs did not always meet each month for the individuals who were past 180 days on the referral list. Although this was not a Settlement Agreement requirement, it was part of the state's policy and would improve the facility's documentation of IDT activity regarding these transitions. • Of the sample of 6 individuals referred for more than 180 days, reasonable activity was taken for 0: o The APC's referral status spreadsheet had a column with one box per individual that gave a brief update of the current status, but it was impossible to determine the month to month activities conducted by the facility, if any. • Of the sample of 3 individuals who were placed after being on the referral list for more than 180 days, reasonable activity and actions were taken for 0: o For all 3, there were large gaps in activity, usually following referral, no activity occurred for up to six months. j. There were no gaps of time (e.g., multiple months) during which little or no activity occurred for 0 of the 9 (0%) individuals. k. Adequate justification was provided for the lengthier transition process for 2 of the 9 (22%) individuals. • For these two individuals, new placements had to be sought after the initial plans of the IDT did not work out (Individual #502, Individual #504).	
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:	<u>State policy</u> a. The state policy for most integrated setting practices was recently issued. It did not address all of the items in section T of the Settlement Agreement. Below are comments from the Monitors: • The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy describes the process of team members making recommendations in their assessments (at III.C.5.c), but does not address having discipline members make a recommendation to the individual and LAR, followed by a full team recommendation being made. The ISP policy addresses, in very global terms, a "living options discussion," and refers the reader to the Most	Noncompliance

		Integrated Setting policy for more details. T.1.b.3 states: "Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spelled out how this will be done. • There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference). • The policy did not thoroughly address the IDT and facility's responsibility in regard to identifying and addressing obstacles to referral and obstacles to transition. • There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). • After referral, there was no description of expectations regarding roles of Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes, provider staff visiting Facility, etc. • The policy did not mention the Settlement Agreement requirement that action be taken <u>prior</u> to the individual's move if pre-move supports are not in place. • The policy did not address the quality of CLDPs. • There was no mention of need for the IDT to use CLDP to ensure supports are in place. • The policy listed two reviews of CLDPs to be undertaken, one at the facility and one at state office, but there were no requirements for any actions to be taken if needed improvements were identified. • There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. o The policy did not, for example, specify any requirement for consideration of enhanced monitoring or follow-up in the event of identified issues or adverse occurrences. • The policy should draw from, and line up with, the metrics submitted by the Monitors and the content of the monitoring reports. <u>Facility policy</u> b. There were not facility policies that supported the state policy for most integrated setting practices. • There was one facility policy related to most integrated setting practices, but it was merely the state policy. The facility, however, should have policies and procedures that operationalize/define implementation of the parts of	

		the state policy that are not specific. Examples include (but are not limited to) the way in which community tours are managed, how educational activities are presented to individuals, how the admissions and placement department staff ensure that all supports and services are included in CLDPs, how the PMM conducts post move monitoring, and which staff are to review the CLDP prior to its submission to the facility director. Training of facility staff on policies is addressed in T1b2 below. The rating for T1b is based solely on the development of adequate state and facility policies. Sections T1b1 through T1b3 are stand-alone provisions that require implementation independent of T1b or any of the other provision items under T1b.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	This section relates to the activities of the IDT, QIDP, and the ISP process. The APC spoke about meeting and working directly with the QIDP Director to address these topics. They should be able to adequately address the metrics in this provision (T1b1) as well as the other ISP-related provisions of section T, which include T1b2 item#1, and all of T1b3. The monitoring team recommends that the APC and QIDP Director begin to collect data on these same metrics as does the monitoring team. <u>Protections, services, and supports</u> a. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted in section F, substantial compliance was not found for F1d, F2a1, and F2a3. For the sample of 6 individuals who's CLDPs were reviewed (see below), 0 individuals had SAPs developed and implemented to help prepare the individual for his or her transition during the period between referral and placement. <u>Obstacles to movement</u> The monitoring team reviewed a sample of 8 ISPs and observed the conduct of 3 annual ISP meetings for monitoring of this provision. The ISPs were submitted by the facility and included individuals from each of the units, some individuals who were not referred, some who were referred, and one who had a failed placement within the past year. Regarding referral at the individual level: b. Of the 8 ISPs reviewed, 5 should have had obstacles <u>to referral</u> defined (the other 3 individuals were referred for transition to the community). Of these 5 ISPs, 2 (40%) included an adequate list of obstacles to referral (attending sex offender treatment program sessions, recent placement of g-tube and need for more exposure to community) . For the others, obstacles to referral were not noted at all (2) or not	Noncompliance

		explicitly stated (1). c. Of the 3 annual ISP meetings observed, an adequate list of obstacles <u>to referral</u> was identified for 2 (67%). • In one case it was LAR preference, in the other it was due to need for further progress in behavior management. A plan to address obstacles at the individual level: d. Of the 5 ISPs, 3 (60%) included an action plan to address/overcome obstacles identified. Of these 3, 0 (0%) were adequate (i.e., were individualized, measurable, and comprehensively addressed the obstacles). e. Of the 3 annual ISP meetings observed, a plan to address/overcome the identified obstacles was included for 1 (33%). Of these, 1 was adequate. • Overall, there was an absence of action plans that directly lined up with the actual obstacles or the reasons behind the obstacles (i.e., the reasons for LAR preference, the reasons why medical needs were an obstacle). Regarding transition at the individual level: f. Of the 6 CLDPs (and related ISPAs) reviewed, 0 should have had obstacles <u>to transition</u> defined. Of these n.a. CLDPs and/or ISPAs related to transition, n.a. (n.a.%) included an adequate list of obstacles to transition. g. Obstacles to transition were defined for n.a. individuals. Of these, n.a. (n.a.%) had action plans to address the obstacle <u>to transition</u>. <u>Preferences of individuals and LARs</u> Preferences of individuals are determined and described: h. Of the 8 ISPs, 8 (100%) included an adequate description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). • 1 of the 8 were unable to clearly provide their preferences. i. Of the 3 annual ISP meetings observed, the individual's preference for where to live was adequately described in 1 (33%), and this preference appeared to have been determined in an adequate manner for 1 (33%). Preferences of LARs are determined and described: j. Of the 8 ISPs, an LAR was appointed for 5. Of these, 5 (100%) included an adequate description of the LAR's preference and how that preference was determined by the IDT. k. Of the 3 annual ISP meetings observed, the LAR's preference for living setting was adequately described in 2 (67%), and this preference appeared to have been determined in an adequate manner for 1 (33%).	

	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.	1. Individualized plan: a. In reviewing 8 recently completed ISPs, 3 individuals had been referred for placement and were engaged in the CLDP process. For the remaining 5, 0 (0%) had a plan that addressed education about community options. Therefore, the following metric could not be assessed: Of these, n.a. (n.a.%) were adequate. Regarding the plans for education in this set of 5 ISPs: • 1 of the 5 (20%) had a list of activities that was individualized and specified what will be done over the upcoming year. It specified that the individual would visit a day program once each week (Individual #80). To meet criteria with this metric, the plan should go beyond a generic provision of information; it should reflect the specific concerns that individuals and families/LARs have raised about the community, as well as reflective of the individual's needs. ○ The most challenging area with regard to education of individuals and LARs/families is individualizing this process. Action plans should target specific types of providers for community tours, identify research that the team would do to answer the individual/LAR's specific questions, include visits to peers with similar needs that had moved to the community, etc. It is essential that teams individualize action plans to address the reasons for the individual, family member, or LAR's reluctance/preference. For example, if an LAR has questions or concerns about the specific supports available in the community, identifying providers with expertise in providing such supports and introducing the LAR or family member to such providers would be important. For some, talking to another guardian or family that has experienced a transition to the community might be helpful. When teams have questions about availability of supports in community settings, these should be researched. ○ In the 3 ISP meetings observed during the onsite review, an individualized plan was not discussed or created. • 0 of the 5 (0%) were in measurable terms and provided for the team's follow-up to determine the individual's reaction to the activities offered. • 0 of the 5 (0%) included the LAR, as appropriate, based upon the content of the ISP. This was also evident in the two ISPs observed. • 0 of the 5 (0%) adequately described how/if the previous year's plan was completed. It may be helpful to: 1. Add some prompts or headers to the ISP shell to help the IDT address each of the	Noncompliance

		above four bullets. 2. Have the transition specialist who attends the ISP meeting ensure that the IDT always adequately addresses these four bulleted items. 3. Train and review these, with data, during the APC-QIDP Director meetings. 2. Provider fair: b. The facility did not hold a provider fair within the past 12 months. Though, a provider fair was scheduled for the week after this onsite review, on 6/12/14. Data were not collected on a variety of variables (e.g., attendance, participation, satisfaction, suggestions) from previous fairs. Data from previous fairs were not used to make changes to new fairs. 3. Local MRA/LA: c. The facility did appear to maintain good communication and a working relationship with the LA. The facility did not participate in quarterly meetings with the LA (only one meeting held in the last six months, in May 2014). Relevant topics were on the agenda for the LA meetings. 4. Tours of community providers: All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to). d. The facility did not have an adequate system to track and manage tours of community providers (i.e., identified all individuals for whom a tour was appropriate, identified all individuals and whether or not each went on a tour). There had been no tours since December 2013. Since the last review, there were three tours, one each in October 2013, November 2013, and December 2013. • To meet this aspect of T1b2, the facility needs to demonstrate that: o All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). o Places chosen to visit are based on individual's specific preferences, needs, etc. o Tours are for individuals or no more than four people. o Individual's response to the tour is assessed. e. The facility did not have data for the following metric: Based on the facility's own report, of the n.a. individuals at the facility for whom a tour was appropriate, n.a. (n.a.%) went on a tour appropriate to their needs within the past year. f. Of the n.a. individuals in the sample for whom their teams had determined a tour was appropriate, n.a. (n.a.%) went on a tour tailored to their needs within the past year. To meet the standard for this item of T1b2, at least 90% of the individuals for whom a tour was appropriate should have attended a tour.	

		5. Visit friends who live in community: g. The facility did not have a process to identify individuals who would benefit by visiting friends who had moved to the community, and a process for making it happen. 6. Education activities at/by facility for individuals: h. Since the last onsite review, other educational activities for individuals did occur (during self-advocacy meeting on 3/25/14), did not occur during house meetings for individuals, did not occur during family association meetings, and did not occur during any other appropriate situations or locations. 7. Education activities for direct support professionals (DSPs), clinicians, and managers: i. More than 75% of DSPs were not documented to have participated in one or more activities (e.g., inservice, workshop, community tour). • 17 QIDPs attended a training on 1/16/14. j. More than 75% of clinicians were not documented to have participated in one or more activities (e.g., inservice, workshop, community tour). k. More than 75% of managers and administrators were not documented to have participated in one or more activities (e.g., inservice, workshop, community tour). 8. Reluctant individuals/LARs learn about successes: l. Since the last onsite review, information about successful community placements was not shared with (a) individuals who were reluctant to consider community placement, and (b) LARs who are reluctant to consider community placement. • The facility did not have a process for this to occur.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and	The monitoring team requested a set of recent ISPs, attachments, and assessments. Eight were selected for review by the monitoring team (see above under Documents Reviewed and description in T1a). These were from the entire MSSLC campus, for individuals with differing levels of needed support, and supported by eight different QIDPs. Five of the ISP meetings were facilitated by the same ISP facilitator. An ISP facilitator was not indicated for the other three. The monitoring team assumed that these were facilitated by the QIDP. The ISPs were from meetings held January 2014 to March 2014. Many of the ISPs did not use the statewide template for living option discussion sections of the ISP. They should. 1. Professionals provided recommendation in assessments: a. Assessments were reviewed for 8 of the 8 ISP. Of the 8 ISPs reviewed, all of the assessments for 0 individuals (0%) included an applicable statement or recommendation from all disciplines.	Noncompliance

	practices.	• The ISPs sampled were from some individuals who were referred and not referred. • Assessments were not completed (or perhaps were completed, but were not submitted) for all disciplines. • The state office new standardized statement/requirement was not being used by all disciplines all the time, but should be. • Below are some data for these 4 ISPs: Discipline # assessments # with a statement # w/ state statement Medical 8 of 8 8 of 8 8 of 8 Nursing 8 of 8 8 of 8 7 of 8 Dental 7 of 8 3 of 7 3 of 3 Psychiatry 0 of 8 Psychology 1 of 8 0 of 1 Pharmacy 0 of 8 OT-PT 7 of 8 7 of 7 5 of 7 SLP 7 of 8 7 of 7 5 of 7 Nutrition 8 of 8 8 of 8 0 of 8 Aud./Vision 8 of 8 8 of 8 0 of 8 Educ./Train 8 of 8 6 of 8 6 of 6 Vocational 7 of 8 1 of 7 1 of 1 Social Work 0 of 8 <u>2. Professional determinations presented/discussed at ISP meeting</u>: b. In 8 of the 8 (100%) written ISPs reviewed, and during 3 of the 3 (100%) annual ISP meetings observed, independent recommendations from each of the professionals on the team to the individual and LAR were included. • Statements were taken from the assessments and inserted into the written ISP for some, but not all, of the assessments. • The ISP did not note whether these professional determinations were stated verbally during the ISP meeting. • In those cases when the medical department wrote to not refer, the reason given was "in conjunction with the team." Instead, the physician's reason should be given. <u>3. Thorough discussion of living options at ISP or other IDT meeting</u>: c. In 1 of the 8 (13%) written ISPs reviewed (Individual #80), and during 0 of the 3 (0%) annual ISP meetings observed, a thorough discussion of living options did occur. • Living options discussions were not adequate. Although there was some discussion regarding different types of living options, there was no discussion of barriers to referral and action plans to address those barriers.	

		4. IDT determination in written ISP: d. In 3 of the 8 (38%) written ISPs reviewed, a complete and adequate statement of the opinion and recommendation of the IDT's professional members as a whole was included. e. In 6 of the 8 (75%) written ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	The APC submitted 12 CLDPs completed since the last review. This was 35% of the 34 CLDPs completed since the last review. The monitoring team reviewed 6 (18%) CLDPs in depth. Timeliness of CLDP Initiation of CLDP a. 0 of the 6 (0%) CLDPs were initiated within 14 calendar days of referral. The monitoring team based this finding by reviewing documentation of CLDP-related activity occurring within 14 days of referral, including the actual 14-day meeting minutes or indication on the CLDP cover/first page. It seemed that 3 of the 6 might have been initiated within 14 days because the individuals were ultimately placed within 180 days, however, there was no documentation. The other 3 were placed beyond 180 days and there were gaps in transition planning activities for many months following referral, therefore, it was likely that those CLDPs were not initiated within 14 days. Ongoing development of CLDP b. 3 of the 6 (50%) CLDPs included documentation (e.g., ISPAs or other document) to show that they were updated throughout the transition planning process. Two others included documentation, but not until six or so months had passed since referral. Some, but not all, CLDPs provided detail about this within the subsections of section IV of the CLDP. The APC maintained a detailed spreadsheet about the status of every referral. It was very useful to her and her department, however, it only contained one small paragraph of information regarding the status of each referral. This did not provide enough information to make a determination regarding ongoing development of the CLDP. IDT member participation in placement process c. 6 of the 6 (100%) CLDPs or other transition documentation included documentation to show that IDT members actively participated in the transition planning process (e.g., 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 monitoring team was impressed with the IDT's	Noncompliance

		involvement with Individual #504's transition. The original plan was for him to move home with his mother, but after the IDT visited the mother's home and neighborhood, determined that it would not be a safe and therapeutic for him and instead pursued, and ultimately placed him in, a community group home. For Individual #502, the IDT found a home closer to his family. This occurred mid-way through the transition process when family member illnesses made it unlikely that they would be able to travel to see him as often as he and they would like. For Individual #754, the IDT traveled to El Paso to evaluate the home to which he was transitioning. <u>Coordination of CLDP with LA</u> d. n.a. of the 6 (n.a.%) CLDPs or other transition documentation included documentation to show that the facility worked collaboratively with the LA. The monitoring team chose to not rate this metric because this collaboration did not appear to be more than the LA's attendance at the CLDP meeting, and the provision of provider lists.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The CLDP document contained a number of sections that referred to actions and responsibilities of the facility, as well as those of the LA and community provider. <u>The CLDP specifies actions to be taken by facility</u> a. 0 of the 6 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 of the activities listed below, in the six closed bullets, occurred adequately and thoroughly. However, each of the CLDPs (100%) included some of these six activities. • Training of community provider staff, including staff to be trained and level of training required. Two of the CLDPs included many pre- and post-move supports regarding training (Individual #347, Individual #502). For Individual #754, training was described as being done over the phone <u>during</u> the CLDP meeting; this was likely insufficient. For the other three individuals, all training was included in a single pre-move support that provided no detail. The APC submitted training rosters documenting training of some staff for one individual, but these were from October 2013, many months prior to the last onsite review. i. who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), 0 of 6 (20%). The CLDPs merely said "staff." ii. 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), 0 of 6 (0%), and iii. a competency demonstration component, when appropriate, 0 of 6	Noncompliance

		(0%). • Collaboration with community clinicians (e.g., psychologist, behavior health specialist, psychiatrist, PCP, nurse, SLP). This was noted in 0 of the CLDPs (0%). If collaboration with community clinicians was considered by the IDT and perhaps deemed not necessary, the CLDP should indicate this decision. • Assessment of settings by SSLC clinicians (e.g., OT/PT). This was noted in 2 of the 6 CLDPs (33%), that is, for Individual #754 and Individual #504. • Collaboration between provider day and residential staff. This was not evident in any of the CLDPs (0%). The CLDP for Individual #347, however, included many post-move supports for the residential provider to conduct training with the day provider. Individual #504 was to attend public school, but there were no supports regarding how collaboration would occur. • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). This was not evident in any of the CLDPs (0%). If not needed, this should be indicated in the CLDP. • Collaboration between Post-Move Monitor and Local Authority staff. The facility reported that the PMM shared all reports with the local authority. It may be helpful to: 1. Include these six items within section IV of the CLDP. 2. Add these six items to the APC's CLDP supports checklist. <u>Documentation of day of move activities</u> b. 6 of the 6 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and the responsible staff member. Documentation for 0 of the 6 (0%) indicated that the activities did indeed occur. The APC submitted an adaptive equipment receipt for one other individual (Individual #333). <u>CLDP meeting prior to moving</u> A CLDP meeting occurred for 6 of the 6 individuals (100%). It was described in each of the CLDPs. c. A CLDP meeting occurred during the onsite review for Individual #455. The meeting ran very well with lots of participation from IDT members, the community provider (Educare in Temple, TX), and the family. The individual also attended, though his participation was limited. The individual's MSSLC PCP, behavioral health specialist, and DSP actively participated. There was discussion of things that were important to him (e.g., his backpack) and what made him uncomfortable (e.g., being in a new setting). The community provider representative was very experienced with transition and her comments, questions, and responses enhanced the meeting. The meeting appeared to demonstrate all seven of the following characteristics of a good CLDP meeting.	

		• Attendance by all relevant IDT members, community providers, and LA • Individual preparation occurred prior to the CLDP meeting, if appropriate to do so • DSP preparation occurred prior to the CLDP meeting, if appropriate to do so • Individual participation occurred, or was facilitated, if needed • There was active participation by team members • All relevant pre-move and post-move (essential/nonessential) supports were discussed and any issues resolved • The post-move monitor actively participated to ensure that supports were adequately defined and required evidence specified.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Staff names provided for all pre- and post-move supports a. For 6 of 6 CLDPs (100%), the facility identified all facility staff and other staff (e.g., LA, community provider staff) by name and title for each pre-/post-move support. Completion timeframes/dates for all pre-/post-move supports: b. For 6 of 6 CLDPs (100%), the facility identified specific timeframes/specific dates for completion and/or implementation for each pre-/post-move support.	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.	Evidence of individual/LAR participation: a. Based on review of 6 CLDPs, 6 (100%) included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by: • signatures on CLDP • narratives in the CLDP	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	In preparation for the CLDP meeting, assessments were updated and summarized prior to the CLDP meeting. Although only minimal progress was found by the monitoring team, the APC had been taking some actions to improve the functionality of the discharge assessments. For instance, she reported that she recently began returning assessments that did not meet criteria, so that the writer could make improvements (the effects of this were not evident in the CLDPs reviewed). Further, she conducted training sessions with the QIDPs and the medical department (and she planned to do more). She said that these sessions went well and that attendees were positive about the requirements. The handouts attached to the documentation for these meetings, however, included the annual ISP assessment template, not a template that would be more useful for writing a discharge summary. The following review was based on a sample of assessments from 6 of the CLDPs.	Noncompliance

		<u>The assessments selected for completion are appropriate and none are left out</u> a. For 6 of the 6 CLDPs reviewed (100%), all necessary assessments were completed. <u>Assessments done within 45 days of move date</u> b. For 6 of the 6 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. <u>Assessments are available for use by the APC and IDT</u> c. For 6 of the 6 CLDPs reviewed (100%), all assessments were available to the APC and IDT prior to the final CLDP meeting. <u>Assessments are of adequate quality</u> d. For 0 of the 5 CLDPs reviewed (0%), the assessments were of adequate quality based upon the following four closed bullets: • A summary of relevant facts of the individual's stay at the facility. o The content of the assessments for most of the assessments for all 6 individuals contained relevant facts regarding the individual's stay at the facility. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. o Most of the assessments for all 6 individuals were thorough enough to assist teams in developing a list of supports. • 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 The set of assessments for 0 of the 6 individuals specifically focused on the new home or day settings. o Many of the nutrition discharge assessments contained a section header "Recommendations when in the community setting," but the content that followed was not specifically written to address the individual's new home and day program. • 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 The assessments for 0 of the 6 individuals specifically focused upon how the necessary supports might need to be provided in these new settings. o This is particularly disappointing for PBSP/psychology/behavioral health supports. There were no recommendations regarding ways the PBSP might be implemented in the new settings. o This was also true for psychiatric supports. Most merely referred to medication. There was one notable exception: the psychiatry	

		discharge summary for Individual #153. In it, the psychiatrist made thoughtful comments hypothesizing about reasons for the individual's success at MSSLC and the importance of considering social and environmental differences in the community. For instance, he noted that the individual's comparatively high level of competence at MSSLC would not likely be replicated in more integrated community settings, a very important consideration for the receiving provider agency, psychologist, and psychiatrist. It may be helpful for the APC to add metric d. to her assessment tracking tool.	
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 departure from the Facility.	The lists of pre-move and post-move supports were identified in the CLDPs. There was continued improvement in the lists of supports, however, more work was needed. Overall, the monitoring team found the most recent CLDP (Individual #347) to be the most complete of the sample reviewed. In addition, good information was included in section IV of the CLDP (though more was needed). The CLDP for Individual #754 had an "Other" section after all of the discipline assessment/recommendation reviews. Here, the IDT discussed any other topics that had not been covered. This was a good idea and led to additional post-move supports being included in his CLDP. The monitoring team again recommends that the APC conduct a self-assessment type review of each CLDP before finalizing it to ensure that the components of sections T1c1 and T1e are adequately addressed. <u>Pre- and post-move support lists are adequate</u> a. In 0 of the 6 CLDPs reviewed (0%), a comprehensive set of essential and nonessential supports was identified in measurable/observable terms. This finding was based on the following three numbered bullets. 1) The list is comprehensive and inclusive, demonstrated by the following eight open bullets: o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ This applied to 6 of the 6 individuals, and was demonstrated in 0 of the 6 (0%). Merely saying to "continue the PBSP as written" or "attend counseling" was insufficient. Further, the CLDPs and PBSPs detailed many aspects about interaction style, communication, preferences, clothing, food, music, schedules, and so forth that were critical to each of these individual's success. This was the case for all 6 CLDPs. • The one exception was for Individual #309. The behavioral health specialist indicated that he would benefit from knowing the "house rules" and, as a result,	Noncompliance

		post-move supports for both the home and day program were included. ▪ More should be garnered from psychiatry. All but one of the CLDPs offered recommendations to continue the current medication regimen, but nothing more. The one exception was for Individual #153 (as noted above), however, none of the psychiatrist's suggestions or comments were used in the list of post-move supports. This was disappointing to see. ▪ Attention should be paid to recent behavioral and/or psychiatric problems. One of the documents for Individual #153 indicated that he had a recent incident of setting a fire. This was a very serious incident that should have been explored by the IDT and all those involved in his CLDP and transition. ▪ As appropriate, crisis intervention plans should be developed, and/or pre-move and post-move supports should define how the current methods for dealing with crises at the facility should be modified in a community setting. This was not in any of the CLDPs, but should have been for anyone with a history of behavioral and/or psychiatric issues. The psychiatry assessment for Individual #309 said to call 911 in a crisis. There were two problems with this. First, there was no discussion as to whether this was the best approach to dealing with his potential behavioral outbursts, and second, there was no mention of this in the post-move supports. Further, he had a post-move support to find a psychiatrist, which meant that the provider had not identified a psychiatrist for him at the time of his transition. o All safety, medical, healthcare, therapeutic, risk, and supervision needs were addressed. ▪ This applied to all 6 individuals and was adequately done for 6 of the 6 (100%). Examples included weight, diabetes, exercise, gym membership, and regular medical monitoring (Individual #754), medication side effects monitoring (Individual #502); high calorie diet (Individual #504); and low calorie diet (Individual #309). For this last example, the CLDP would have been improved if it included supports for increasing the likelihood of the individual regularly following the diet. o What was important to the individual was captured in the list of pre- and post-move supports. ▪ This applied to all 6 and was adequately addressed for 5 of 6 (83%). Individual #153's post-move supports included what appeared to be boilerplate supports, some of which were not	

		listed anywhere as his preferences. The monitoring team saw these preferred-type supports in almost all of the CLDPs. o The list of supports thoroughly addressed the individual's need/desire for employment, and/or other meaningful day activities. ▪ Employment or day supports applied to 6 of the 6 individuals and was adequately addressed for 1 (17%) (Individual #347). Post-move supports to attend day hab and to apply to DARS were insufficient for four other individuals, especially because these individuals wanted to work, had experience working at MSSLC, and wanted to make money. IDTs should be concerned about the amount of time (e.g., months) that the individual might be waiting for employment. Individual #504 was still in high school, but given that he was past 16 years old, employment should have been addressed, as per national special education standards (the CLDP had him referred to a day hab program when not in school). o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included in the list of pre- and post-move supports. ▪ This was addressed in 0 of the CLDPs (0%). Positive reinforcement applied to all individuals and probably played a considerable role in their success at the facility. o There were pre-/post-move 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 addressed for 3 (50%). o There were pre-/post-move supports for the provider's <u>implementation</u> of supports for 0 of the 6 (40%). This refers to the components of the PBSP, PNMP, dining plan, medical procedures, nursing care plans/IHCPs, therapy and dietary plans, and communication programming that community provider staff would be required to continue were not included. o All recommendations from assessments are included; or if not, there is a rationale provided. This occurred for 6 of the 6 CLDPs (100%). ▪ For the most part, recommendations were included. ▪ The APC or placement coordinator wrote very detailed narratives of the discussion and deliberation that occurred for each of the disciplines during the CLDP meeting and how the discussion led to a set of what they called final recommendations. 2) The wording of every pre-/post-move support is in measurable, and observable terms.	

		○ Many were in measurable terms, however, many continued to include wording, such as encourage to brush teeth, implement current BSP as written, and would like to participate in recreational activities. 3) Every pre-/post-move support included 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. ○ This was much improved and included more references to logs, checklists, and interviews. ○ The PMM should guide the IDT to consider <u>three</u> general categories of evidence: direct observation, staff interview, and documentation (e.g., checklists). Most of the supports for Individual #754 were written in this way. ○ For many supports, the documentation was "service logs" (e.g., Individual #309, Individual #504) If this refers to the standard HCS service log, the PMM must make sure that adequate information is recorded. The monitoring team has found that these statewide HCS forms often do not, and cannot, include the information that the PMM will need. If so, and as has been done successfully with many providers, a specialized checklist can be made. <u>Essential supports were in place on the day of the move</u> b. For the 6 of 6 (100%) CLDPs reviewed for individuals who were placed, a pre-move site review was conducted by the facility. c. Of these 6, 6 (100%) were done timely and completely. d. Of these 6, 6 (100%) indicated that all of the essential supports were in place prior to the individual's move, or if they were not, identified the issue and showed that action was taken to remedy the situation. All of the pre move site review forms were completed adequately, however, the form for Individual #502 contained more detail than any of the others and, therefore, was most useful to the IDT. e. For___ of __ (%) pre-move site visits observed by the monitoring team (if any), the pre-move site visit was conducted thoroughly (not applicable, none were observed by the monitoring team).	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the	Policy/Procedure a. There was not a written policy or written process for quality assurance to ensure the (a) development and (b) implementation of CLDPs. • The state recently developed and disseminated the beginnings of a section T/most integrated setting practices QA program to each of the facilities. It included three tools to assess the written completed CLDP document, written completed post move monitoring forms, and the written completed transition document for provision T4 type transitions. It included two sets	Noncompliance

	provisions of this Section T.	of instructions (one page each). One was for the conducting of the three tools. The other was regarding the full set of transition-related data and review system. • The content of the three tools lined up better than ever before with the content of the monitoring team's metrics and reports. The state should again review the Monitors' reports for the next revision of these tools. • Tools regarding the important ISP-related components of section T were not addressed (e.g., T1a, T1b1, T1b2, T1b3). • The facility should have its own facility-specific policy/procedure for quality assurance to meet what is required by this provision T1f. Collection of data b. Data/information were being collected (but a complete set of data were not being collected). The data that were being collected were relevant and valid. The data appeared to being collected reliably. • The monitoring team has, for some time now, recommended the following set of data to contribute to the APC's QA program and to set the occasion for summation, review, and analysis of data. These are simple data to collect and graph. Some of it was already being done and good progress was seen. Those items are indicated with check marks. 1. √ Number of individuals placed each month or monitoring period 2. √ Number of new referrals each month or six-month period 3. √ Number of individuals on the active referral list as of the last day of each month 4. √ Number of individuals on the active referral list for more than 180 days, as of the last day of each month 5. √ Pie chart showing the status of all of the active referrals (e.g., CLDP planned, move date set, exploring possible providers). 6. Number of individuals who have requested placement, but have not been referred, as of the last day of each month 7. 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 8. Number of individuals not referred solely due to LAR preference as of the last day of each month 9. √ Number of individuals who had any untoward event happen after community placement each month (including return to the facility or death) ▪ Cumulative number of each type of untoward event for all placements (√ returns, √ deaths) ▪ number that had a root cause type review	

		10. √ Number of rescinded referrals each month or each six-month period ▪ number that had a root cause type review 11. √ Number of alternative discharges (T4) 12. Number of individuals whose ISPs identified obstacles to referral and placement, and whose ISPs identified strategies or actions to address these obstacles (from T1b1) 13. √ Number of individuals who went on a community provider tour each month and total number/percentage of individuals who went on a tour in the past 12 months (from T1b2) Summarization/analysis of data and actions taken c. Data were reviewed and somewhat summarized (in a single sentence, or two), but not analyzed. There was no narrative or explanation of the data. Actions were not taken as a result of analysis of the data. The data were included in the facility's QA program and presented quarterly to QAQI Council. The most recent presentation and data were 4/24/14. Re-admissions: There was 1 re-admission. This compared with 1, 2, 0, 1, and 0 re-admissions at the time of all of the previous reviews. d. For 0 of the 1 (0%) who returned to the facility after a failed community placement, an adequate review was conducted to determine if changes in the referral and transition planning processes at the facility should be made. Of these reviews, actions were recommended in n.a. cases. Of these n.a. cases, actions were implemented for n.a. (%). Deaths Following Community Placement: There were no deaths of individuals who had moved to the community. This compared with 0, 1, 4, and 0 deaths prior to this review. Because there were no deaths of individuals who had moved to the community, the following metric was not applicable to this review. e. ___ individuals that transitioned to the community passed away since the last onsite review. Of these, there was an adequate review conducted to determine if changes in the referral and transition planning processes at the facility should be made for (%) of the cases. Of these reviews, actions were recommended in ___ cases. Of these cases, actions were implemented for ___ (%). Other Adverse Outcomes: f. Over the past six months, 14 of the 56 individuals placed in the past year (25%) experienced one or more potentially negative outcomes since placement. Of these, there was an adequate review conducted for 0 (0%) of the cases to determine if changes in the referral and transition planning processes at the facility should be	

		made. Of these reviews, actions were recommended in n.a. cases. Of these n.a. cases, actions were implemented for (n.a.) (%). The APC said that she received some training in root cause analysis procedures from the facility's IMC, however, upon further exploration it turned out to be a training on how to do an investigation of an incident. The APC would benefit from training in the analysis of data and ways to continually improve the quality of the APD and the facility referral, transition, and post placement monitoring services. The monitoring team read the APD meeting minutes for February 2014 through May 2014 (six meetings). In the first of these, 2/5/14, there appeared to be some discussion of ways their system might be improved (e.g., ensuring providers make individuals aware of all expectations [Individual #442], develop a checklist to assure that all identified items go at the time of move [Individual #118, however, the monitoring team thought this was already occurring for all moves], and develop timelines that are reasonable [Individual #236, Individual #333]). The monitoring team could not determine, however, if any of these were implemented or monitored. The other two meetings in February 2014 had standing agenda items and noted "none reviewed." The meetings for March 2014 through May 2014 did not have any discussions and the items did not appear on the standing agenda.	
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,	Annual narrative by facility a. The facility did not have an adequate system to collect information about obstacles to transition. • The monitoring team found that obstacles were not adequately identified in the ISPs. Thus, the data in the facility's system were suspect (see T1a). • The facility's data system, when completed, should also indicate if any "compromises" of the individual's needs, preferences, and/or supports were required in order for the transition to occur. An example of a compromise would be if the individual "settled" for a day habilitation program because the vocational program that the team recommended (or that the individual preferred) was not available in the part of the state in which the individual/guardian wanted to live. Another example would be if the individual moved to an area of the state that was not the original preference because clinical services were not available there. • One set of data were in the FY13 report with data through 8/31/13 (close to one year ago). A second set of data were data 5/8/14 and listed obstacles for 62 individuals with 28 of these being individual or LAR indecision. Because these data were labeled obstacles to transition, the monitoring team assumed these were for individuals who were already referred. If so, it might not be that every individual who is referred had an obstacle to transition. Being in the process of choosing a provider should not be	Noncompliance

	and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	considered an obstacle to transition. b. The facility did not have an annual narrative that showed it had (a) conducted a comprehensive assessment of obstacles, and (b) developed and implemented appropriate actions to address and overcome these obstacles on the local level within the authority of and resources available to the Facility. • The narrative, for most of the obstacles to transition, only described the problem. Moreover, there were repeated references to numbers of individuals for whom an obstacle to transition existed, but were now placed. Thus, it was not clear how the situation was (or perhaps was not) an actual obstacle to transition. • The report did not lead to new or general strategies to address the types of obstacles to transitions for individuals who were already referred. Annual narrative by DADS state office c. The State did not present an annual narrative that showed it had (a) conducted an analysis of the Facilities' data, (b) taken 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, and (c) as appropriate, DADS made efforts to seek assistance from other agencies or the legislature. DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/13 from all 13 Facilities. The report was issued to the Monitors and DOJ on 3/27/14, seven months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 6 obstacles to referral categories and 12 obstacles to transition areas used in FY13. • DADS included a list of 14 initiatives it was continuing to support. • The report included attachments with each of the Facilities' annual reports. • The validity of the obstacles to referral data appeared to be more accurate than in previous years' reports. However, as noted in the monitoring team's reports, concerns still existed with teams' accurate identification of obstacles. The following concerns were noted with regard to the report: • <u>Transition obstacles data</u>: Adequate methodologies were not described as to how data regarding obstacles to transition were determined and collected. For example, it was not clear if one individual could have had more than one obstacle, and/or if different obstacles presented themselves at different times during the transition process. Further, the data should describe whether these obstacles to transition were overcome. As a result, the validity of the data	

		provided in the report was questionable. Further, it would be useful to formalize the process to identify obstacles far ahead of the 180-day goal (i.e., not wait until 180 days have passed before identifying and documenting obstacles). o State office staff reported during recent discussion with the Monitors, that anytime the IDT identified an obstacle to transition, it should be included into the database. Further, state office staff said that their data system allowed for an individual to have more than one obstacle to transition and indeed many individuals did have more than one obstacle in the data. The data system, however, did not track, or report on, whether obstacles were successfully addressed (i.e., whether the individual had not yet moved and/or whether compromises had to be made). The monitoring team believes that this information should be included in the report. • DADS strategies: DADS included a list of strategies and actions, however, they did not thoroughly address some of the most frequently cited obstacles that the Facilities had identified. For example, according to the 2013 Annual Obstacle Report Data spreadsheet, 353 individuals were not referred due to "Behavioral health/psychiatric needs requiring frequent monitoring...," 308 individuals were not referred due to "Medical needs requiring 24-hour nursing…," and 1698 individuals were not referred due to "LAR's reluctance for community placement" (almost 50% of the population of all of the facilities). Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at Austin SSLC. Although these appeared to be worthwhile activities, few strategies specifically addressed the above three categories: behavioral/psychiatric (strategies 7 and 8), medical-accessibility (strategies 9 and 10), and LAR preference (perhaps strategies 1 and 12b). Moreover, given that many of the strategies were repeated (or slightly modified) from last year's report, an update on the status of each would be appropriate to include in this report. o During recent discussion with state office staff, the staff agreed that better overall analysis was needed in order to tie identified obstacles to their set of statewide strategies (and/or to ensure that there were strategies to address the most-often identified obstacles to referral and to transition). • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). o The monitoring team was unable to determine this because there was no information in the report addressing it.	

T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	a. The facility did provide an accurate Community Placement Report for six months ending on the week prior to the onsite review (9/1/13-4/27/14) that included the following information: • Number and names of individuals transitioned to the community • Number and names of individuals on active referral list • Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference (there were 29 names, though it was not clear if these were individuals for whom LAR preference was the sole reason for no referral)	Substantial Compliance
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of	MSSLC met substantial compliance with this provision item. Overall, post move monitoring was done thoroughly and competently. Follow-up occurred when needed. Providers responded and individuals were doing very well in the community. The PMM was responsive to comments and recommendations from the last onsite review and monitoring report.	Substantial Compliance

	three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Since the last review, 101 post move monitorings for 45 individuals were completed. This compared to 69 post move monitorings for 29 individuals, 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 26 post move monitorings for 11 different individuals. Of the 26 post move monitorings, 18 were completed by the post move monitor Pam Gonner, and 8 by Gail McLain, placement coordinator. <u>Timeliness of Visits</u> For the 45 individuals, 101 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 101 required visits, 101 (100%) were conducted and 98 (97%) were completed on time. Of the 26 post move monitoring forms reviewed by the monitoring team (for 11 different individuals), all 26 (100%) included dates showing that they were completed on time. <u>Locations visited</u> For the 26 post move monitorings reviewed, 26 (100%) indicated that the PMM visited the locations at which the individual lived and worked/day activity (e.g., day program, employment, public school) were visited. Some individuals did not attend a day program. <u>Content of Review Tool</u> 26 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. The PMM used the newest iteration of the form for these post move monitorings. The post move monitoring report forms were completed correctly and thoroughly, as follows • The checklist was completed in a cumulative format across successive visits for 15 of the 15 (100%) 45- and 90-day visits. • Supports were verified, such as by indication of the evidence examined and the results of this examination, in 26 of the 26. o The PMM should now provide detail in her report regarding: ▪ Whether she had evidence of all aspects of required training and inservicing, such as who, what, how, and documentation of competency (rather than merely stating training documentation was reviewed). This was a problem in many of the reports. For example, for Individual #236, the PMM wrote "observed that all staff was inserviced at this time." The report for Individual #502, however, included detail about training.	

		▪ The post move monitoring form had a column labeled "Evidence reviewed." However, the monitoring team could not determine what the CLDP called for. • The monitoring team recommends that the PMM include the CLDP-required evidence as well as what she looked at. Often, the PMM looked at more than what was required, in part, because the CLDP did not provide enough direction or did not provide the proper direction. • The PMM should ensure that the CLDP includes sufficient detail regarding the evidence to be examined, including interviews, documentation, and observation. As a participating member of the CLDP meeting, she has the opportunity to do so. • Each post move monitoring report (100%) included a review of all pre move supports (as it should). The yes/no boxes were marked in each post move monitoring report. • There was adequate justification for findings for each support in 26 of the 26 (100%). • Detail/comment was included in 26 of the 26 (100%) reports for every support. o The monitoring team suggests that the PMM provide additional detail than what she typically provided so that the reader can more fully understand the status of the support. • LAR/family satisfaction with the placement and the individual's satisfaction were explicitly stated in 23 of 26 (88%). • An overall summary statement of the post move monitor's general opinion of the residential and day/employment placements was provided by the PMM in 0 of the 26 (0%). o A short overall paragraph should be included. • 17 of 26 reports (65%) indicated the specific name and title of each person interviewed by the PMM. The non-occurrences were from January 2014 and February 2014. This error was corrected in all of the more recent reports. The monitoring team has the following additional comments, which need to be addressed by the PMM and APC for the next onsite review: • The PMM was inconsistent in the yes/no scoring of items that were not occurring. For example, some items were scored yes, even though they were not yet scheduled to occur and had not yet occurred, such as appointments (e.g., Individual #502). For other individuals (e.g., Individual #236), these were scored as no. All of these should instead be scored as n.a. • Some items were scored incorrectly. For instance, Individual #700 was no	

		longer participating in cooking due to an error he made with the microwave, but it was scored as a yes. Individual #313 was not receiving counseling because the provider had not identified a provider, but this was scored as n.a. Even so, the PMM presented this second example to the MSSLC IDT, which was good to see. Both of these examples should have been scored no. • When the CLDP calls for the PBSP to be implemented, it is insufficient for the PMM to merely report on whether or not there was a behavior problem. The PBSP has lots of other components (e.g., interaction style, reinforcement and rewards, teaching of replacement behaviors), therefore, the PMM should be looking for evidence of implementation of these other components. This should also be addressed in the post-move support list in the CLDP. • A general statement (e.g., a short paragraph) by the PMM describing her overall opinion about the home and day/work program needs to be included. <u>General status of individuals</u> Based upon the monitoring team's review of documents and discussion with the APC and PMM, of the 11 individuals who received post move monitoring who were reviewed by the monitoring team, 11 (100%) transitioned very well and appeared to be having good lives. Numerous other individuals, however, experienced problems in the community (about 25% as described above in section T1f, metric f.). As discussed with the APC, a root cause type of review needs to be done for any individuals whose placements failed or who had the kinds of problems noted in T1f. <u>Use of Facility's best efforts when there are problems that can't be solved</u> In 12 of the 26 post move monitorings, additional follow-up, assertive action, and activities were required of the post move monitor. These were for 8 of the 11 individuals. The problems were of a minor nature, such as counseling or other appointments not having occurred yet, attending a school different than what was in the CLDP, minor behavior problems, and minor medication changes. During observation of post move monitoring (T2b below), the PMM identified a serious problem with staff training. She took immediate action and required the provider to implement actions that very day. <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 to be held and there were to be minutes/documentation of the meeting following post move monitorings for which an ISPA was appropriate to have been held. An ISPA meeting was necessary for 12 of these post move monitorings and was held for 12 of the 12 (100%).	

T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	MSSLC maintained substantial compliance with this provision. The monitoring team observed one post move monitoring at the day program and group home of Individual #569 for the 45-day review. The PMM, Pam Gonner, did a thorough and complete job of 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 • 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 PMM's report, completed a few days after the post move monitoring visit, was an accurate reflection of what was observed by the monitoring team. The provider was Cen-Tex. It appeared to be a good placement for the individual. The day program was about a mile from his home and he safely rode his bicycle to and from day program. Further, the home was nearby to his mother and he rode his bicycle to visit her. These were important supports identified in his CLDP. During the visit, the PMM learned that the individual moved to a new group home (this home, with the same provider) following a behavior outburst by a housemate that greatly upset Individual #569. The PMM found that staff training at the new home had not occurred. She insisted that the provider conduct training later that same day, which they agreed to do. Even so, during the visit to the home (which was prior to the staff training session), the home staff were very knowledgeable about the individual, in part, because they coincidentally worked or had worked at MSSLC and knew Individual #569.	Substantial Compliance
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to	This item does not receive a rating.	

	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		
T4	**Alternate Discharges –**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible	Fifteen 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 5 of these individuals was reviewed. All five were discharged under court orders/direction. Three were discharged, assigned to their family or LAR. Two were determined to be fit to proceed and were discharged to the court system. A clerical error was noted in two of the summaries. In both of these, some information regarding a different individual appeared to be inadvertently included on the last page (Individual #934, Individual #367). <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, 5 out of 5 (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 5 out of 5 records reviewed (100%), good cause was identified in the discharge summaries (i.e., court order/direction). • 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 0 out of 5 individuals (0%). If reasonable time was given to prepare, it was not evident because all 5 of the discharge summaries were completed after the individual moved. For 3 of the 5, the summaries were completed on 5/13/14, more than a month after moving and possibly in response to the monitoring team's request for these discharge summary reports. • The facility developed a final summary of the individual's developmental, behavioral, social, health and nutritional status, and the information was adequate for 5 out of 5 individuals (100%). Some were missing the section headers, which if included, would make it easier for the reader to find the	Noncompliance

		information. For 1 of the 5, a description of his behavioral history was given, not a report of the current status of his behavioral needs and programming. • For 0 out of 5 individuals (0%), the facility provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving facility. The facility submitted letters sent to the individual, however, they were dated months after the individual had moved. Four of the five were dated 6/10/14 for discharges that occurred between February 2014 and April 2014. • Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the report for 5 out of 5 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 o MSSLC Prioritized Need for Guardianship List o MSSLC Self-Assessment and Provision Action Information for section U o MSSLC Section U Presentation Book o A Sample of HRC Minutes o Documentation of activities the facility had taken to obtain LARs or advocates for individuals o ISP, Rights Assessment (for a subsample): • Individual #113, Individual #884, Individual #386, Individual #261, Individual #211, Individual #80, Individual #816, Individual #521, and Individual #535. Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; o Joy Lovelace, Human Rights Officer o Charlotte M. Kimmel, Director of Behavioral Services o Patrick Samuels, Incident Management Coordinator o Ramona Echols, QIDP Director o Craig Burgess, Assistant QIDP Director o Don Morton, Assistant Director of Programs Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 6/2/14 and 6/3/14 o Longhorn Morning Unit Meeting 6/4/14 o PET II Meeting for sections C, D, K, and J o ISP preparation meeting for Individual #539 o Annual IDT Meeting for Individual #557 and Individual #519

#	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	The parties agreed the monitoring team would conduct reduced monitoring for this subsection because the facility had made limited progress. The noncompliance finding from the last review stands. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	policy because it should assist the facilities in moving forward with regard to the Implementation of the Section U Settlement Agreement requirements. Two annual ISP meetings were observed, for Individual #557 and Individual #519. IDTs were not holding adequate discussions regarding each individual's ability to make informed decisions. Teams did not develop training opportunities to improve decision making skills, even at the most basic level (e.g., simple choice making). The facility self-assessment indicated that of the 20 ISPs reviewed for the discussion of the individual's ability to give or withdraw consent: • 35% contained some discussion • 60% contained inadequate discussion • 5% contained no discussion A sample of ISPs was reviewed by the monitoring team 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. 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. 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	The parties agreed the monitoring team would conduct reduced monitoring for this subsection because the facility had made limited progress. The noncompliance finding from the last review stands. New guardianship had not been obtained for any individuals at the facility in the past six months. The Human Rights Officer continued working with many current guardians to renew guardianship on an annual basis. The facility had some rights protections in place, including an independent assistant ombudsman housed at the facility, and a human rights officer employed by the facility. The facility continued to offer self-advocacy opportunities for individuals at the facility, through the self-advocacy group and somewhat through the weekly home meetings.	Noncompliance

#	Provision	Assessment of Status	Compliance
	entities seeking to advance the rights of persons with disabilities.	Compliance with U2 will be contingent on ensuring that all individuals have been assessed using the newly developed assessment process. It will be important for the human rights officer to continue to work with IDTs to ensure assessments are completed and teams engage in an adequate discussion of each individual's needs.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: 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 recordkeeping policies, so not reviewed again) • New policy, on Facility Policies and Procedures, 6/1/14 o MSSLC organizational chart, 5/12/14 o MSSLC policy lists, May 2014 o List of typical meetings that occurred at MSSLC, undated but likely May 2014 o MSSLC Self-Assessment, 5/9/14 o MSSLC Action Plans, 5/19/14 o MSSLC Provision Action Information, 5/12/14 o MSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 6/2/14 o List of all staff responsible for management of unified records o Description of changes since the last onsite review (none) o List of other binders or books used by staff to record data o Description of the shared drive o Tables of contents for the active records and individual notebooks 4/5/13, and master records (March 2014) o CTD monthly training data, December 2013 to May 2014 o Active record check out data, March 2014 to April 2014 o URC and record clerk inter rate agreement data, March 2014 to April 2014 o Individual notebook monitoring data October 2013 to April 2014 o Example of QIDP list of SAPs from the ISP (11/7/13), and blank PSI list of assessments o Master record birth certificate questionnaire and list of every individual, April 2014 o Policy status spreadsheet, including training data for many, 6/5/14 o Blank policy training continuing education sheet and training acknowledgement form o Training conducted regarding new policies policy, 3/28/14 o Example of a discipline department meeting regarding policies, 3/31/14 o Description of the unified record audit process o Blank unified record audit tools o Draft of new tool that was in development o List of individuals whose unified record was audited by the URCs, December 2013-May 2014 o Completed audits for 10 individuals, March 2014 and April 2014 • Active record and individual notebook • Master record • Statewide self-monitoring tool

	• Additional notes/comments for each audit o Interobserver agreement information for October 2013 through March 2014, including minutes from monthly meetings with QA department about interobserver agreement o Medical consultation tracking sheet used for doing audits (none) o Blank inter-rater tool, revised, February 2014 o Emails to department heads regarding corrections needed and/or problems identified as a result of the unified record audits, November 2013 to April 2014 o Audit tracker, September 2013 through January 2014, showing follow-ups through April 2014 o Statewide tool data and graphs through April 2014 o V4 items: active record checkout log and graphs, PBSP data card monitoring graph, missing lost data graphs, March 2014 and April 2014; and V4 interview tool results, presence of active records at meeting, February 2014, March 2014 and April 2014 o Recordkeeping PET meeting, QA report, and QAQI Council presentation materials, March 2014 to May 2014 o Active records and/or individual notebooks of: • Individual #896, Individual #539, Individual #790, Individual #529, Individual #266, Individual #272, Individual #432, Individual #535, Individual #243, Individual #816, Individual #990, Individual #989, Individual #468, Individual #120, Individual #702 o Master records of: • Individual #863, Individual #92, Individual #550, Individual #108 <u>Interviews and Meetings Held</u>: o Sherrie Price and Debbi Reichert, Unified Records Coordinators, and Elaine Schulte, Director of Client Records o Patty Thompson, Settlement Agreement Clerk, coordinator of policy-related data o Various staff across MSSLC campus <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area
	Facility Self-Assessment The self-assessment was improved from the previous onsite review. More items were included for each provision and the items that were included lined up more with the contents of the monitoring report than before. Even so, the monitoring team again recommends that the self-assessment contents line up directly with the contents of the monitoring report. V1 of the self-assessment reported only on the data from their V3 reviews. Although this was very good information and was appropriate to include, the monitoring team looks at a variety of other aspects of recordkeeping practices when rating V1. This is evident in the report below.

	For V2, the self-assessment captured the important aspects of that section. That is, whether policies were developed, reviewed, revised, and implemented; and details about the training of staff. For V3, the self-assessment correctly reported on the system of the quality assurance audits and whether they were implemented correctly. Aspects missing were the summarization and analysis of data and the development and implementation of any resultant actions. The V4 self-assessment correctly looked at the six components of that section. 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: The recordkeeping department continued to make progress across all four of the sections of this provision. Substantial compliance was maintained for V1. Sixteen of 16 (100%) individuals' records reviewed included an active record, individual notebook, and master record. A unified record was created for all new admissions. The URCs, DCR, and record clerks engaged in a number of activities to increase the likelihood of the unified record meeting substantial compliance. Some were continued from the time of previous reviews; some were more recently initiated. 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 2-3 errors/missing documents per active record. Active records remained in overall good shape. Individual notebooks continued to be used for all individuals and as per state policies. The monitoring team talked with staff in each of the units. All seemed comfortable with, and knowledgeable of, the individual notebooks. Master records were improved since the last review. For section V2, a well-organized system was now in place. With the completion of the remaining policies and the completion of the training of the remaining staff, the facility should be able to obtain substantial compliance. Five quality assurance 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 database of medical consultations was no longer being used to inform the URCs as to what consultations were conducted. This needs to be started again and should go back for 12 months.

	Errors were reported to the responsible person and follow-up occurred for two months. A small percentage of errors (less than a third), however, were corrected. The URCs had a set of graphs that were presented in the QA report and at PET and QAQI Council meetings. Unfortunately, a set of appropriate graphs and data were not being kept and, in part, as a result, the type of analysis and action planning required by this section were not done. The facility had taken actions since the last review regarding the components of section V4 and, as a result, had made progress. The facility was in substantial compliance with two of the six items, #5 and #6 (33%).

#	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 maintained substantial compliance with section V1 and continued to make progress across the other three sections of this provision. To conduct this review, the monitoring team examined aspects of the unified record for more than a dozen individuals, reviewed documents and reports, talked with various staff at the homes and day programs, and observed records in use in the program sites and during various meetings. Sherrie Price and Debbi Reichert continued as URCs under the supervision of Elaine Schulte, Director of Client Records. The URCs took most of the lead in the management of recordkeeping activities and initiatives related to provisions V1, V3, and V4. Patty Thompson remained the lead for section V2. The set of home record clerks remained stable, with only one new appointment since the last review. The stability of the staff across the recordkeeping department contributed to the maintenance of performance observed during the last review and to continued progress towards substantial compliance. State policy remained the same as in previous review. The overall facility-specific recordkeeping policies also remained the same. A new policy was written to address the management of policies. This is addressed in V2 below. The table of contents and maintenance guidelines for the active records and individual notebooks remained the same. The table of contents for the master records was updated in March 2014. The URC actively participated in the facility's QA program. This included completing a quarterly QA report and monthly presentations to the PET. Sixteen of 16 (100%) individuals' records reviewed included an active record, individual notebook, and master record. A unified record was created for all new admissions.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Active records The status of the active records maintained since the last review. The monitoring team reviewed active records in four of the five units at MSSLC. The URCs, DCR, and record clerks engaged in a number of activities to increase the likelihood of the unified record maintaining substantial compliance. Some were continued from the time of previous reviews; some were more recently initiated. • The table of contents continued to provide guidance to all staff, however, it needed to be updated. There were numerous document changes that were not reflected in this old form. Further, some items on the table of contents should be asterisked (e.g., service objectives, PRT, SIT); items were missing from the table of contents (e.g., sexual behavior assessment, smoking assessment, additional standard medical consultations); and one item was duplicated (consent authorization/rights restrictions). • Recordkeeping practices continued as a part of NEO. Data from the CTD department showed high rates of completion. • 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. This continued since the last review. • 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. This was reported continued since the last review, however, the only example given to the monitoring team was from November 2013, which was prior to the last onsite review. • 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. o The monitoring team, however, did not find that the books were being used correctly or that the data were accurate. For example, in Shamrock 2, some active records were signed out but present, and some were missing but not signed out. The monitoring team suggested to the URCs that a point-in-time data collection might be more accurate and, therefore, more helpful when providing feedback to home managers and unit directors. • The URCs continued to keep what they called the delinquency list. This was a facility wide list kept by the record clerks of all missing or out of date documents. There were approximately 166 per week across the facility in April 2014 and the URCs reported that May 2014 data showed less than 100. • Audits by record clerks were just initiated within the last month. Each month, one of the five record clerks was to do a full review for one of the other homes.	

#	Provision	Assessment of Status	Compliance
		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 2-3 errors/missing documents per active record, an improvement since the last review. The frequency of problems with legibility and signatures had also decreased since the last review. Two other areas of improvement were inclusion of some narrative in the daily observation notes (i.e., not only filling in the check marks on the form), and the presence of more ISP monthly reviews (e.g., Individual #896, Individual #539). The errors found by the monitoring team included an ADR filed as the last page of the social history section (Individual #790); an AMA more than one year old (Individual #272); and IPNs with gaps at the end of many of the pages (Individual #432). The URCs' own data from their five monthly audits regarding errors/missing documentation was not summarized or calculated, but should be. Instead, they presented the record clerks' delinquency data (i.e., for the entire facility, presented as monthly data and as weekly data) that showed about 3 per individual active record in February 2014 and March 2014, and dropping to about 1 per individual active record in May 2014. <u>Individual notebooks</u> Individual notebooks continued to be used for all individuals and as per state policies. An individual notebook existed for each individual. The notebooks were managed by the residential unit staff. 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. Individuals did not carry their own individual notebooks. In cases where the individual requested to do so, a second copy was made for the individual. All individual notebooks contained the ISP and the IRRF, but not the IHCP. IHCPs should be available to DSPs because they need to be knowledgeable about the health care needs, plans, and required actions for each individual. The monitoring team talked with staff in each of the units. All seemed comfortable with, and knowledgeable of, the individual notebooks. For example, on L3, Jerry Hayes, DSP II, showed the monitoring team how he (an the other DSPs) used the individual notebooks for level of supervision monitoring, observation notes, and PBSP data (which were recorded up to the current hour interval). In Shamrock 2, PBSP data were also recorded up to the current interval. While in Shamrock 2, the monitoring team observed Lori Wiley, DSP II, complete what she called her "five o'clocks." That is, she made sure to	

#	Provision	Assessment of Status	Compliance
		record all of the PBSP and level of supervision data right at five o'clock, as required by these PBSP programs. Overall, the content of the individual notebooks was appropriate and complete. Timely recording of behavior data had increased to 83% from 64%. Active treatment coordinators continued to conduct monthly maintenance reviews of the content and quality of every individual notebook. They completed an Individual Notebook monitoring form for each. Data were graphed for the past seven months and ratings by these staff were approximately 90%. <u>Other binders/logs</u>: There were no changes in the use of other binders or logs since the last review. That is, 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 managed by the nursing department, not the recordkeeping department. In some homes, SAP data sheets were kept in a separate binder; these were managed by the education and training department/master teachers. <u>Master records</u> A master record existed for every individual at MSSLC and all were in a format that was organized, manageable, and improved from what was described in previous reports. Each record contained a blue page that detailed what was present and what was missing. Overall, the master records were in good shape. The improvements to the master record system were: • A new table of contents/cover blue page was created and added to every master record. It included new sections (tabs) for medical and psychiatry (and these two new sections were now in each master record, too). The cover page also had a column for the recordkeeping staff to indicate presence of the document. The cover page was completed for about a third of the master records, with a plan for full completion over the next few months. • There was an improved system for documenting information about missing documents. The recordkeeping staff put a piece of paper, as a placeholder, where the document would have been that stated the status of the document, and what activities had been done to obtain it (if any). • The focus upon obtaining birth certificates, described in the previous report, had been fairly successful. The recordkeeping staff said that birth certificates were	

#	Provision	Assessment of Status	Compliance
		obtained for all but 58 individuals. Birth certificates are extremely important for individuals to have, especially when they are transitioning to the community and will be looking for employment. <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.	Much progress was made in this section, moving the facility closer to substantial compliance. There was an improved process and a more organized system. Patty Thompson managed the facility's performance for this section. Not all state policies were in place yet, though continued progress was evident. State policies existed for 17 of the 20 provisions (all but G, H, and updates to U). The facility had a facility-specific policy for sections G and H, but it was in draft format and not yet implemented. Thus, the facility had policies in place for 17 out of 20 Sections of the Settlement Agreement (85%). Procedures for managing policies were now driven by a new policy. It was called "Facility Policies and Procedures I.B.1," and it was implemented on 6/1/14. It described how state policies, once disseminated, were to be handled at the facility (i.e., dissemination, training, documentation). It also described how facility-specific policies were to be handled, including QAQI Council review and approval of new policies, and an annual review of all other policies. The policy also described the tracking of policies and the training documentation required by this section. A new training acknowledgement signature form was now required from the policy-responsible person or from CTD department. Ms. Thompson's tracking spreadsheet included relevant information regarding policies, status, and training requirements. She had not been, but will start, doing semi-annual updates of all training data so that data in her spreadsheet are never more than six months old. Training data were reported for 15 of the 20 sections (75%), data were no more than six months old, and all relevant staff were trained for 8 of the 20 (40%). Now that a well organized system was in place, with the completion of the remaining policies and the completion of the training of the remaining staff, the facility should be	Noncompliance

#	Provision	Assessment of Status	Compliance
		able to obtain substantial compliance.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Five quality assurance 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 The URCs were beginning to work on a new audit tool that incorporated both the statewide tool and the table of contents tool. This has been recommended in previous monitoring reports and has been done by many of the other SSLCs. It was good to see the URCs beginning to work on this. They might benefit from obtaining samples from other SSLCs. The database of medical consultations was no longer being used to inform the URCs as to what consultations were conducted. This needs to be started again and should go back for 12 months. The URCs continued to use the ISP to help them determine what SAPs should be in the active record. Inter rater agreement checks were done by a QA program auditor once per month on one of the five audits. The agreement checks were now done for the table of contents tool and the statewide tool. The URCs wrote a monthly note about the results. Overall, findings were very positive and item-by-item agreement percentages were very high. Items needing correction were counted separately in two categories. One set of data were called documentation errors (i.e., legibility, signatures, etc.), the second set were called delinquency errors (i.e., missing or incorrect documents). It was good to see this separation, however, as recommended in previous reports, the data should also be combined into a total number of errors. Some items in the audit tool were scored as yes, but with notes that indicated that some aspect of the item needed correction. These were also included in the email to the responsible staff person and in the audit tracker. It seemed that these were counted in their data as a "no," even though they were scored as a yes (but this was impossible to determine because no summary data for the five audits was kept by the URCs).	Noncompliance

#	Provision	Assessment of Status	Compliance
		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: 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 continued to be used to make it easy for each discipline department to identify the corrections that they were responsible for correcting. Then, the URC followed-up to determine whether corrections were completed. 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. A small percentage of errors (less than a third), however, were corrected. The URCs had a set of graphs that were presented in the QA report and at PET and QAQI Council meetings. Unfortunately, a set of appropriate graphs and data were not being kept and, in part, as a result, the type of analysis and action planning required by this section were not done. Below is a list that the URCs can use to develop a full set of graphs and some comments regarding the status of their current graphs and analyses. • Average score on statewide self-assessment tool portion of the audit. o For the first time, these data were being graphed each month. o The data should be reviewed and analyzed. Actions should be taken based upon the data. • Total number of corrections need for all five reviews. o These data were not being graphed. This should include the total of documentation errors and delinquency errors. • Documentation errors data (this is a subset of the total number in the above closed bullet) o Data were being graphed for the five audits. It was summarized facility wide by type of documentation error (there were six different types), and by residential unit. No changes needed here, continue doing this in the same manner. o No analysis was occurring. • 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. The	

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		numbers, however, were included on the unit-by-unit monthly graphs. o No analysis was occurring. o These data were being tracked for the entire facility based upon data from the record clerks. This was part of the way the facility sought to improve the quality of the active records as described in section V1. • Percentage of items that were corrected within the specified two-month time period. o Data were being collected, but no longer summarized, graphed, or analyzed. • A data set and graphs for the V4 activities. o Some progress was seen here as describe below in section V4. • The URCs continued to graph two other sets of data, which was great to see: o Active record check out procedures (though there were problems with the way the data were being collected) o Individual notebook monitoring (done by the active treatment coordinators). 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.	There are six types of activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. The monitoring team reviewed all six with the URCs. They had taken actions since the last review and, as a result, made progress. The facility was in substantial compliance with two of the six items, #5 and #6 (33%). Below, the six areas of this provision item are presented, with some comments regarding MSSLC's status on each. <u>1. Records are accessible to staff, clinicians, and others</u> An active record check out system was put into place, but was not working very well. Further, the clerks were monitoring whether the form was filled out correctly rather than whether missing active records were signed out correctly and that when returned, were signed back in. A point in time check on this would be a better way to monitor. As noted above in V1, the monitoring team did not find the check out logs to be accurate.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Data on the availability of the active records and the accuracy of the check out log is one type of information that could be collected by the facility to monitor this aspect of V4. Another could be the presence/availability of individual notebooks. Record accessibility during meetings is addressed in item #6 below. The monitoring team also observed that: • Numerous departments complained about records (active records) not being available, and sometimes, they could not be located. • Individual notebooks (which contained PBSP data sheets) were generally accessible to DSPs. • Current ISPs were available in all individual notebooks. • The monitoring team reviewed Individual #297 and #185's records onsite, and located the necessary information in the individuals records related to documentation of meeting (ISPA) and assessment and treatment for an episodic event. • Records were accessible to the psychiatrist during clinic. • Therapy staff documented consistently related to all supports, services and interventions in the IPNs and SAPs. <u>2. Data are filed in the record timely and accurately</u> 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 could be used to satisfy this aspect of V4, too. In addition, they might consider doing an occasional comparison of what is in the electronic shared folder (which probably contains the most recent documents) to see if what is in the active record corresponds to what is in the shared folder. The monitoring team also observed that: • Timely recording of target and replacement behaviors dramatically improved. SAP data were recorded in the individual records, and appeared accurate. • QIDP monthly reviews indicated that data on progress towards ISP outcomes were not always available for review. • At two ISP meetings observed, data relevant to the risk discussion were not	

#	Provision	Assessment of Status	Compliance
		readily available for review or the accuracy of data could not be confirmed. • Items requested for review were found chronologically in the individual's record. • Information was consistently recorded in the IPNs. Findings of effectiveness monitoring were documented on a separate form and in the IPNs. <u>3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> The URCs had begun to collect data on status of PBSP data cards, education and training department SAPs, and monthly ISP reviews. The latter of these is probably belongs in item #2 above. Food intake, bowel charts, and seizure logs are other examples of data that could be included for this item. The monitoring team observed that: • 83% of behavior datasheets reviewed by the monitoring team were recorded in a timely manner. • For individuals who were prescribed medications to treat constipation, which relied upon the BM logs as to whether or not the individual may receive a PRN medication, the BM or lack of a BM was not consistently documented on the BM log. For example, Individual #988 had omissions. • The therapy clinicians consistently used a combination of data sheets, IPNs, and monthly summaries to consistently document direct supports and services. <u>4. IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> The URCs reported that they looked to see if IPN entries contained more than only nursing entries. This was a good start, but more work needs to be done to develop a way to assess this. The monitoring team observed that: • For the records reviewed, the active record was referred to and used when documenting in the IPN. For example, Individual #185's fall and skin integrity issues were observed by the monitoring team. The IPN note included a review of previous skin integrity issues, previous falls, and previous treatment strategies. • Effectiveness monitoring was documented on a monitoring form to determine if the supports were addressing the identified need (PNMP), though this was infrequent. It could not be determined, however, if all aspects of the PNMP were reviewed at the same frequency as this was not clearly established in the assessment and did not appear to be tracked on a systemic level.	

#	Provision	Assessment of Status	Compliance
		5. Staff surveyed/asked indicate how the unified record is used as per this provision item This continued, data were recorded, and responses were regularly rated at 100%. In addition, the monitoring team observed that: • The monitoring team asked nurses, how the record was used to make care, treatment, and training decisions. For each of the questions posed, the responses were consistent that the record "should" be reviewed, and gave these examples: check allergies prior to taking a medication order, review how the individual takes/prefers to take his or her medicine, and response to treatments that were not effective. The monitoring team found evidence of this when reviewing individuals who had a change in health status. For example, Individual #255's treatment required an antibiotic. • 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). 6. Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item, and data are reported rather than only clinical impressions The intent of this item is for the record to be present and available, and that it is used when, and if, needed, such as if there is a question about data, diagnoses, incidents, etc. Many times, there is no need to open the record because IDT members do not need to access additional information. In other words, it is possible to satisfactorily meet this component if the record is present, not used, and no examples of it failing to be used when it should have been used. The URCs reported that the ISP facilitators collected data for them on the presence and use of the active record during annual ISP meetings. The monitoring team found the following: • The active record was present at the annual ISPs for Individual #519 Individual #557, and at the pre-ISP for Individual #539. The active record was used by the PCP and nursing during the meetings. • The active record was present at the CLDP meeting for Individual #455. • The QIDP facilitator provided IDT members with a draft ISP and IHCP at the annual team meetings for Individual #519 and Individual #557. Data from assessments were entered into these two forms so that team members could reference current assessments when developing necessary supports. • For Individual #519, the team spent considerable time discussing behavior that resulted in numerous restrictions, incidents, and injuries. However: o A functional assessment was not available to assist the team in	

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		developing effective supports. The behavioral health specialist had to leave the meeting to find behavioral data when team members disagreed on the status of his behavioral outcomes. o Some team members expressed concern regarding insomnia. The team did not have reliable sleep data available to review. • During Individual #557's risk discussion at the annual ISP, the nurse noted that Individual #557 had several incidents of vomiting during the past year. Specific data regarding the incidents were not available, thus, the team was unable to adequately address the effectiveness of her supports. • The active record was present during an ISPA held for Individual #297. It was evident in the presentation of information during the ISPA that the RN Case Manager had researched record prior to the meeting when contributing to recommendations for continued care and treatment. • Psychiatry rounds observed indicated use of the active record to make treatment decisions. • Active records were not available during the PNMT meeting, but each team member was assigned to conduct record review prior to the meeting in order to report various elements of the individual's current status.	

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
ACB	Anti Cholinergic Burden
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
ACS	Assessment of Current Status
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
ADS	Annual Dental Summary
AEB	As Evidenced By
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFB	Acid Fast Bacillus
AFO	Ankle Foot Orthosis
AHA	American Heart Association
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
BHS	Behavioral Health Services
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
CI	Clinical Intervention
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)
EBWR	Estimated Body Weight Range
EC	Enteric Coated
EC	Environmental Control
ECG	Electrocardiogram
ED	Emergency Department
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
H&P	History and Physical
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
JNC	Joint National Committee
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
MCC	Medical Compliance Coordinator
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
NHLBI	National Heart, Lung, and Blood Institute
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 Instructions
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
PD	Program Developer
PDD	Pervasive Developmental Disorder
PDR	Physicians Desk Reference
PECS	Picture Exchange Communication System
PEG	Percutaneous Endoscopic Gastrostomy
PEMA	Psychiatric Emergency Medication Administration
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
POC	Polypharmacy Oversight Committee
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
RBBB	Right Bundle Brach Block
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
RPO	Rights Protection Officer
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
VP	Ventriculoperitoneal
VPA	Valproic Acid
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs
VZV	Varicella Zoster Virus
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