United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

Dates of On-Site Review: March 22-26, 2010

Date of Report: May 28, 2010

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Table of Contents

Background 3
Methodology 4
Organization of Report 5

Executive Summary 7

Status of Compliance with Settlement Agreement
- Section C: Protection from Harm – Restraints 16
- Section D: Protection from Harm – Abuse, Neglect, and Incident Management 28
- Section E: Quality Assurance 44
- Section F: Integrated Protections, Services, Treatment, and Support 57
- Section G: Integrated Clinical Services 71
- Section H: Minimum Common Elements of Clinical Care 74
- Section I: At-Risk Individuals 77
- Section J: Psychiatric Care and Services 84
- Section K: Psychological Care and Services 85
- Section L: Medical Care 103
- Section M: Nursing Care 104
- Section N: Pharmacy Services and Safe Medication Practices 118
- Section O: Minimum Common Elements of Physical and Nutritional Management 122
- Section P: Physical and Occupational Therapy 148
- Section Q: Dental Services 162
- Section R: Communication 165
- Section S: Habilitation, Training, Education, and Skill Acquisition Programs 180
- Section T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs 191
- Section U: Consent 213
- Section V: Recordkeeping and General Plan Implementation 216

Health Care Guidelines 219

List of Acronyms 222

I. Background

Background - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement (SA) covers 12 State Supported Living Centers, 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 (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement, the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the facilities assigned to him or her every six months, and detailing his or her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the Monitors of the status of compliance with the SA. This report provides a baseline status of the Mexia State Supported Living Center (MSSLC).

In order to conduct reviews of each of the areas of the Settlement Agreement and Healthcare Guidelines, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry and medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in the review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in the report for a section for which another team member had primary responsibility. For this baseline review of Mexia SSLC, the following Monitoring Team members had primary responsibility for reviewing the following areas: Teri Towe reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, treatments and supports, and consent;

Karen Green McGowan reviewed nursing care and dental services; Gary Pace reviewed psychological care and services, and habilitation, training, education, and skill acquisition programs; Carly Crawford reviewed minimum common elements of physical and nutritional supports as well as physical and occupational therapy, and communication supports; and Alan Harchik reviewed serving individuals in the most integrated setting, , record keeping, and quality assurance. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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 SA.

II. 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 March 22 through March 26 2010, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. This allowed the Monitoring Team to gain some basic knowledge about facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living and discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including

documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. 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 being implemented.

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

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 facilities.

III. 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 and each chapter of the Health Care Guidelines.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each facility, this section will highlight, as appropriate, areas in which the facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which 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 SA and each of the chapters of the HCG, 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) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the facility has with regard to compliance with the particular section;

(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, 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;

(d) **Facility Self-Assessment:** A description is included of the self-assessment steps the facility undertook to assess compliance and the results thereof. The facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the facility self-assessments for reviews beginning in July 2010;

(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "noncompliance") is stated; and

(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. It is in the State's discretion, however, to adopt a recommendation or use other mechanisms to implement and achieve compliance with the terms of the SA.

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. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

First, the monitoring team wishes to acknowledge the outstanding cooperation and responsiveness of all staff members at all levels at MSSLC. A review, such as this, is impossible to complete without the willingness of management, clinicians, and direct care professionals to provide the team with a variety of information. Throughout the week of the on-site tour, MSSLC assisted monitoring team members with scheduling meetings, interviews, and observations; obtaining documents and reports; getting around campus; and answering a myriad of questions. Further, this required many MSSLC staff to re-arrange their schedules, tour team members around the facility, include team members in meetings, participate in interviews, and allow themselves to be observed conducting their typical job activities. The monitoring team also acknowledges the willingness of many individuals to talk about their lives at MSSLC and to be observed in their daily day, work, and home activities. The facility director, William Lowry, helped set the tone early, specifically inviting the monitoring team to learn everything possible about MSSLC. Further, he instructed all of his staff to be open and to answer all questions posed to them by team members. This collaborative approach was right in line with the way the parties intended for the monitoring process to occur.

As a result, a great deal of information was obtained during this tour as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations were conducted, and interviews were held. Specific information regarding more than 100 individuals is included in this report. It is the hope of the monitoring team that the information and recommendations contained in this report are both credible and helpful to the facility.

At the time this report was issued, information was not available with regard to the facility's status with Sections J (Psychiatric Care and Services), and L (Medical Care). The Monitor apologizes for the inconvenience that this may cause to the facility and its management team.

Second, the monitoring team found management, clinical, and direct care professionals eager to learn and to improve upon what they do each day to support the individuals at MSSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong on-site tour. Although it is difficult to provide much technical assistance during a baseline tour, team members found opportunities to share ideas and make suggestions. Their comments were well received. The team hopes to continue to provide suggestions and recommendations and has done so throughout this report.

Third, below some general themes found by the monitoring team are discussed.

Settlement Agreement

- Clearly, members of the senior management group at MSSLC were well aware of the Settlement Agreement and its many provisions. Throughout the week, monitoring team members and management staff easily and fluidly discussed specific provisions and provision items, often referring to them by item letter and number. This indicated the seriousness with which the management staff had taken the Settlement Agreement. Along with this, again, were their numerous comments regarding wanting to provide services that were as good as they could possibly be. Middle managers and clinicians were less aware of the Settlement Agreement, however, the monitoring team expects that, over time, more attention will be paid to ensuring these other levels of staff are also well informed about the Settlement Agreement.

Caring Practices

- The monitoring team observed many examples of caring practices at MSSLC. Hospice care was provided to those who were in the latter stages of terminal illnesses, and overall medical and nursing care was a focus of the facility. Although more work needed to be done in providing services that were fully integrated, MSSLC attempted to consider all aspects of the individual's life, including a focus on teaching new skills across a range of areas, such as personal hygiene and vocational skills.

Community Placement

- MSSLC staff prided themselves on their mission of achieving successful community placement. Indeed, a large number of individuals had been placed and many more were in the placement and referral processes. As indicated below in this report, the monitoring team raised some cautions and concerns regarding the rapidity of discharges, the completion of treatments at the facility before discharge, ensuring the community providers were prepared for the individuals (many of whom had very challenging and complex support needs), and the community's overall capacity for successfully supporting the individuals.

Facility Transition

- There was a lot of discussion at MSSLC regarding the upcoming changes at the facility, especially with the specialization as a forensic facility. It is important, however, that the facility always take into consideration that it will be serving more than one population. Consider that the facility will be supporting individuals with forensic histories, as well as those with more severe to profound multiple disabilities, including those who are medically fragile. Moreover, the facility will be supporting both juveniles and adults. This will require thoughtful planning and an ability to vary policy, procedure, and implementation based on each population's

needs and characteristics. The monitoring team was also encouraged by the plan to reduce the number of individuals in each home to 12 or less.

Integration of Services

- Throughout this report, there are comments regarding a need to improve the integration of services. That is, that teams need to ensure that information from various sources, including, but not limited to, assessments and evaluations, data from previous goals and objectives, the preferences and strengths of the individual, knowledge of staff and family members about the individual, and so forth is synthesized into a plan that comprehensively addresses the individual's preferences, personal goals, and needs. At the same time, facility management needs to ensure that there is no marginalization of any professional discipline, that is, that all disciplines have the opportunity to participate and contribute to the service provided. In particular, integration of the medical and psychiatric disciplines should be a priority for the facility.

Staff Members

- MSSLC was fortunate to have a wealth of experienced staff at all levels who had many years of experience. In many cases, staff began as direct care professionals and had advanced into important management positions, thus, allowing them to have an important perspective about the day to day work required to meet the needs of the individuals at MSSLC. Senior management at MSSLC should be sure to gain input from the facility's many departments, divisions, and staff as it moves forward towards meeting the provisions of the Settlement Agreement. An increase in staff recognition, celebrations of success, and responsiveness to suggestion box items are recommended as well as ensuring that staff opinions are heard and respected at team meetings. Further, special attention should be paid to setting a tone and climate in which staff do not fear retaliation, getting in trouble, or losing their jobs if they present opinions in the hope of improving services.
- There were numerous instances of staff being placed off duty due to allegations that turned out to be spurious. This made it difficult to adequately staff and supervise individuals. The overall improvement of programming may lead to a decrease in these apparently false accusations. The monitoring team also recommends that the facility and DADS seek advice from other facilities that have faced similar problems, such as other facilities within the DADS system, other facilities around the country serving individuals with dual diagnoses of developmental and psychiatric disabilities, and/or other types of facilities, such as correctional facilities.

Educational Services

- There were tremendous problems with the provision of educational services to which many of the individuals were entitled. The facility and local school district will need to work together to ensure that the students attend school, have appropriate Individual Education Plans, and receive appropriate instruction. This is addressed in more detail below in this report, in section S.

Immediate Attention

- Throughout the report to follow, many details and examples are provided that identify positive practices that were occurring at the facility as well as a variety of areas that were in need of attention and improvement. Some of these areas required more immediate attention to ensure that individuals were not at any risk of harm. Some of these areas of service were as follows:
    - the assignment of proper risk levels to individuals,
    - proper positioning during meal times,
    - presentation of proper food textures, size, and pacing,
    - medication error rates,
    - spurious allegations that competed with providing a sufficient number of adequately trained staff in the residences, and
    - ensuring that all required supports are in place prior to transition to the community and during all post-move monitoring visits.

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

Restraints

- MSSLC collected data regarding the use of restraints, and had done so for many years. The number of restraints had increased over the previous year, but there were numerous factors that could have played a role in this, including a high number of discharges and new admissions. Moreover, the MSSLC had become the facility to which adult and juvenile male alleged offenders were referred from across the state. Even so, the facility managed to reduce the use of mechanical restraints and protective equipment. Further reduction of the need for restraint intervention (both emergency and as part of a safety plan) may occur if the facility were to incorporate more usage of positive reinforcement contingencies, use behavioral interventions other than verbal prompts prior to restraint, and address desensitization programming to reduce restraints related to medical procedures. Overall, however, MSSLC was, for the most part, following the DADS policy on restraint usage. More details are provided below in section C of this report.

Abuse, Neglect, and Incident Management

- Many allegations of abuse and neglect at MSSLC were filed over the past year. Many of these were filed by individuals who lived at the facility. Some were with merit and were confirmed, however, the majority were unconfirmed. This large number of unconfirmed, false allegations created a challenging problem for the facility in that all alleged perpetrators needed to be put off duty until an investigation was completed. This caused numerous staffing problems and treatment implementation difficulties. This is discussed in more detail in section D below. Overall, however, the facility implemented investigation procedures according to policy. One area noted below is that there appeared to be inconsistency in the reasons for why one agency did or did not take the lead on certain investigations (i.e., DFPS, OIG, local law enforcement).

Quality Assurance

- MSSLC had an active quality assurance program. A lot of data were collected and many staff were involved in the process. Further work will need to be done to meet all of the requirements of this provision of the Settlement Agreement, including, for example, the implementation of corrective action plans, design of a comprehensive QA plan, and ensuring the validity and reliability of all QA measures.

Integrated Protections, Services, Treatment, and Support

- MSSLC was only in the beginning stages of addressing the integration of protections, services, treatment, and support. Moreover, the DADS policy was still in draft format. PSPs were developed with an apparent goal to capture each individual's needs, goals, preferences, and abilities in one document, but there was little evidence of true integration of all services into one comprehensive plan. A sample of PSPs were reviewed and a number of annual PSP meetings were observed during the onsite monitoring visit and, although much information was included in the plan and discussed by the PST, outcomes resulting from planning were often not individualized to reflect the individual's preferences and stated vision. The cover page of each PSP included a list of "what's most important to the person." These lists tended to be individualized and would be a great starting point for the development of individualized outcomes, but this information was not incorporated into prioritizing outcomes for the individuals. PSPs should offer a complete picture of the individual's preferences and vision for the future and describe any supports that the individual needed throughout his or her day. When comprehensive policies are in place to address PSP development, the facility needs to be sure that QMRPs receive updated training on developing plans, and a system is put into place for monitoring plans to ensure all treatments and supports for each individual are addressed in each PSP.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- The need for the integration of clinical care was evident at MSSLC and comments regarding this are noted throughout this report. The state was in the process of developing policies to guide the facility in meeting these provisions of the Settlement Agreement. Achieving integration will be a facility-wide process, that is, it will require that all departments and all levels of staff participate.

At-Risk Individuals

- MSSLC was making efforts to revise the system for identifying and monitoring risk factors for individuals at MSSLC. A Health Status Team was in place and was chaired by the facility's medical director. The facility had developed a data base to be used by all HST members to ensure assessment information was updated and readily available to PSTs. Nevertheless, there were problems in the implementation and interpretation of the policy. As a result, many individuals who should have been rated as being at high risk were rated as being at low, or no, risk. Consequently, their conditions did not receive the type of oversight and review that they required. Many individuals received treatment, or were hospitalized, for conditions that should have, but didn't, result in their risk being rated at a higher level.

Psychological Care and Services

- The monitoring team looked at a variety of areas of psychological and behavioral programming and was most surprised to find an absence of the use of positive reinforcement to support the development and maintenance of appropriate behaviors. Further, many psychological assessments were very outdated. Positive behavior support plans did not contain all of the components one would expect to find in a comprehensive plan. Data collection procedures also needed improvement to provide accurate, reliable, and useful information to treating clinicians. Peer review processes for the thorough review of behavioral programming did not exist. A large amount of effort at MSSLC went into implementing a variety of treatments other than PBSPs. These did not appear to be evidence-based, nor were they individualized, goal-directed, or connected to measureable outcomes.

Nursing Care

- Many positive aspects of nursing care were observed at MSSLC, including infection control and communication with local hospitals. Further, nurses appeared to extensively involved in the daily care of individuals. Issues for the nursing department included having enough staff (i.e., employee) nurses to regularly and consistently provide care (a number of nurses were provided by outside agencies), documentation, medication administration, regularly completing head to toe physical assessments, and providing comprehensive nursing care and treatment for typical, but important, conditions seen in this population, such as GERD and respiratory problems.

Pharmacy Services and Safe Medication Practices

- The facility only recently hired a director of pharmacy services who was a Doctor of Pharmacology. Many of the processes and procedures regarding pharmacy and medication practices were being reviewed at the time of this onsite baseline tour. It is hoped that the pharmacy department will become a more integrated part of the service provision at MSSLC.

Physical and Nutritional Management

- MSSLC had a system of PNM supports and services that included a group that met monthly to address a variety of PNM concerns. Documentation was well organized, readily identifying PNM issues and status based on extensive record review by clinicians prior to the meetings. Follow-up, however, was inconsistent and risk levels were decreased quickly without sufficient time for individuals to maintain a stable health status. A number of issues were observed by the monitoring team to indicate that PNMPs were not consistently and properly implemented. There were numerous examples of inadequate implementation of these plans by staff. The current system of monitoring was ineffective in the identification and remediation of these errors, and this put individuals at risk of harm for aspiration and/or choking, and increased the potential for tube placement. Implementation problems observed included errors in positioning of the individuals, the use of proper adaptive equipment and utensils, and the texture, size, and consistency of food that was served to them.

Physical and Occupational Therapy

- There were insufficient clinical staff to ensure that all individuals received appropriate and timely physical and occupational supports and services. PT and OT assessments needed to present a better picture of the individual. PT and OT also needed to be integrated into the more meaningful programming in the day areas. Therapy interventions should relate more towards the achievement of a measurable goals and functional outcomes for each individual.

Dental Services

- Dental services at MSSLC were innovative and strove to provide services to individuals regardless of their physical or behavioral disabilities, including creative approaches to desensitize individuals to help them to be more comfortable and accepting of dental procedures.

Communication

- MSSLC had dedicated speech and language therapists and technicians, however, the department was woefully understaffed and it was unlikely that the current staff would be able to meet the requirements of this Settlement Agreement provision. In addition, communication and language assessments were not current, and did not

incorporate a contemporary model of augmentative and alternative communication. General communication devices (i.e., those that can be readily used by most individuals) were not available, individualized AAC devices were rarely seen, and staff rarely took advantage of naturally occurring opportunities to promote language use, even for those individuals for whom language and communication were important skills in need of development.

Habilitation, Training, Education, and Skill Acquisition Programs

- MSSLC devoted extensive resources to skill training for individuals. For example, there were 15 master teachers who were assigned to work on skill acquisition programming for the individuals across the facility. The plans, however, needed to incorporate more evidence-based instructional procedures that have been shown to be effective in improving the skills of people with developmental disabilities. Recently, active treatment coordinators had been hired to focus upon the engagement of individuals in interesting and functional activities. Some data are presented below in section S of this report. The educational services for individuals who were under age 22 and still entitled to a public education, however, were fraught with problems. MSSLC had a trying relationship with the local independent school district and work will need to be done, with DADS assistance, to ensure that these students receive the educational services to which they are entitled.

Most Integrated Setting Practices

- MSSLC staff prided themselves on their focus on successful placing individuals in the community and being knowledgeable about processes, policies, and laws surrounding community transition. Many individuals had been placed, most in community group homes, over the past year. The referral process was active at MSSLC. Even so, the monitoring team found reasons for concern, particularly around the rapidity of some of the transitions and the preparation of community providers, especially when preparing to support individuals who had histories of serious challenging behaviors, including alleged criminal activity. Please see details presented below in section T of this report.

Consent

- MSSLC was beginning to address the requirements of this Settlement Agreement provision. A newly disseminated DADS policy was going to be used to guide the facility in identifying and prioritizing those in need of guardianship, and in seeking out appropriate individuals to serve as guardians.

Recordkeeping and General Plan Implementation

- MSSLC was also preparing to implement new procedures in accordance with the new DADS policy. A recently revised table of contents for each individual's active record had also recently been finalized. New materials (e.g., binders, dividers) had been ordered.

The comments in this executive summary were meant to highlight some of the more salient aspects of this baseline review of MSSLC. The monitoring team hopes that the comments throughout this report are useful to the facility as it works towards meeting the many requirements of the Settlement Agreement.

The monitoring team looks forward to continuing to work with DADS, DOJ, and MSSLC.

Thank you for the opportunity to present this report.

V. 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 #002.1: Protection from Harm – Abuse, Neglect, and Incident Management
o DADS Policy #001: Use of Restraint
o Restraint Checklist Form 4012008R
o Administration of Chemical Restraint Form
o MSSLC Limitation of Restraint as a Crisis Intervention Policy
o MSSLC Pre-Service Training Handbook
o MSSLC Annual Retraining Handbook
o Restraint Data and Trends 09/06 –0 2/10
o Injury from Restraint Log 07/09-01/10
o Human Rights Committee Meeting Summaries from 11/09-01/09
o Sample of 63 Completed Restraint Checklists 07/09 – 03/10
o Human Rights Committee Meeting Summaries 11/09-01/09
o Sample of 10 Restraint Debriefing, Review, and Face-to-Face Assessment for Crisis Intervention
o List of Individuals with Safety Plans 02/10
o Log of emergency use of psychotropic medication since 07/09
o Administration of Chemical Restraint Consult for last three chemical restraints
o Performance Evaluation Team Summaries from 11/4/09, 01/7/10, 02/18/10, and 03/4/10
o Daily Incident Review Team Meeting Summaries for the following time periods:
    • 7/20/09-7/24/09
    • 9/21/09-9/25/09
    • 12/14/09-12/18/09
    • 2/1/10-1/5/10
o Training transcripts and background checks for the following employees:
    • Patrick Samuels, Investigator
    • Four DCP Assistants
o Sample of PSPs including:
    • Individual #331 1/6/2010
    • Individual #8 12/3/09
    • Individual #387 1/6/10
    • Individual #502 1/5/10
    • Individual #216 3/15/10
    • Individual #134 2/3/10
    • Individual #101 1/12/10
    • Individual #330 2/10/10</td></tr>
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	• Individual #38 3/8/10 • Individual #63 2/4/10 Interviews and Meetings Held: o Informal interviews with various staff in homes and day programs throughout campus o Interview with Dr. Charlotte Kimmel, Director of Psychology Services o Interview with Chris Christensen, Psychologist for Martin Unit Observations Conducted: o Whiterock Morning Management Meeting 3/24/10 o Daily Incident Management Meeting 3/24/10 o Human Right Committee Meeting 3/23/10 o Shamrock 701, 703, and 705 o Barnett B7 and B8 o Whiterock W2, W3, W7, and W8 o Longhorn L1, L3, L4, and L6 o Martin M1, M2, M4, and M6 o PAWS Program o STEP Program o Woodshop o Laundry/Folding Workshop o MISD Classroom at MSSLC
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Emergency and program restraint data provided to the monitoring team from FY06-FY10 (1st half) indicated a decreasing trend in the use of restraints at MSSLC. The summary of data credited "heightened training in intervention techniques prior to restraint, efforts by professional staff to provide more direct supervision and on the spot correction, and creation of a committee to focus on efforts made to reduce restraints for the reduction." The data did not reflect any specific information on restraint incidents included in these numbers, so it is unknown what types of restraints were being used less often or what other factors might have impacted these numbers. By combining program and emergency restraint data into one trend, the facility did not have a clear picture in regards to where progress was being made in the reduction of restraints. Furthermore, in this review, the monitoring team concentrated on restraint incidents occurring between July 2009 and February 2010. Data showed that there had been a 20 percent increase in restraints when comparing this time period with the same time period from the previous year with 422 restraints

	documented between July 2009 and February 2010, compared to 351 restraints documented between July 2008 and February 2009. A similar collection of data in regards to medical, programmatic, and protective mechanical restraints indicated that there were significant decreases in the use of mechanical restraints in these three categories between FY08 and FY10. Data showed that there were seven incidents of medical restraints used from July 2009 through January 2010 compared to 29 for the same period the previous year. Protective restraints from the same two time periods showed a reduction of 50%, from eight incidents down to four incidents. Program restraints were reduced from seven incidents to one incident for the same time period. Again, without additional detail on the types of restraints included in these numbers, it was difficult to determine what types of restraints were used less frequently and what steps were taken by the facility to reduce these numbers. The facility utilized two types of physical holds. The first was a baskethold applied by one staff in a standing position. If an individual required more than one staff to safely manage him or her, the individual was put on his or her side on the floor and held by as many staff as were necessary. According to the Director of Psychology, if an individual rolled to his or her stomach and staff could not immediately return the individual to a side, staff were instructed to discontinue the hold. The Director of Psychology reported that MSSLC policy was that if an individual had three or more holds in a 30-day period, a safety plan was to be developed. At the time of the on-site tour, the facility had 29 safety plans. Any decrease in restraint usage at MSSLC was also likely due to an increase in the use of antecedent procedures such as offering choices and avoidance of activities that led to the behaviors that typically provoked restraints. Additionally, each restraint was reviewed by the Director of Psychology and with staff, to identify ways that the restraint could have been avoided. The monitoring team believes that restraint use would decrease substantially more if the positive behavior support plans (PBSPs) included more potent consequences (e.g., contingent receipt of strong positive reinforcers, potential to fail to earn a privilege) to encourage the occurrence of positive behaviors incompatible with the dangerous behavior that can lead to restraint applications (see K9). At the time of the on-site tour, the facility had only one contingent application of protective equipment. There were, however, several applications of medical restraint. The monitoring team reviewed two individuals with medical restraint plans (Individual #411, and Individual #401) and found that both had positive PBSPs to decrease the target behavior that provoked the medical restraint. Even so, it was not evident throughout the monitoring visit that MSSLC had made it a clear priority to ensure that restraints used for behavioral intervention that were not part of a safety plan would only be used as a last resort measure. Documentation of restraints showed little evidence of behavioral interventions other than verbal prompts were attempted prior to the use of restraints. There were 56 injuries resulting from the use of restraints at the facility from July 2009 through January 2010. All of these were categorized as non-serious injuries. The facility needs to review these incidents

	for any trends that may be occurring and develop a plan of action to reduce the number of injuries due to the use of restraints. The facility had a restraint reduction committee in place to review restraints and make recommendations for reducing the use of restraints. The Director of Psychology Services shared that the committee looked at trends for the facility, homes and individuals and made referrals to individual teams to review restraints and make recommendations regarding specific individuals. This process was not reviewed in detail during this monitoring visit, but will be looked at further during future monitoring visits. On a positive note, the facility had prohibited the use of mechanical restraints for crisis intervention and it was found that there was an interdisciplinary effort being made on reducing the need for protective, medical, and dental restraints. In order to have a clear picture of where restraint reduction efforts need to begin, the facility should develop a system to collect data on restraint use by individual, staff involved, date, and time, and analyze those data to identify trends. Reduction efforts need to focus on any obvious trends and strategies that may prevent behavioral situations from escalating in specific situations.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	Assessment of this item required review of policies and an examination of implementation of those policies. State and facility policies existed to address the provisions of the Settlement Agreement regarding restraints. The state policy was labeled "Use of Restraints," numbered 001, and dated 8/31/09. It included five addenda guidelines and forms. The facility policy addressing restraints was titled "Limitation of Restraint as a Crisis Intervention" and dated 5/15/09. It too contained addenda forms to be used in the documentation of restraints. The use of prone and supine restraint was prohibited by the DADS policy. In addition, the use of mechanical restraints other than approved protective restraints had been discontinued by the facility according to interviews, though the facility policy still included mandates regarding the use of mechanical restraint for crisis intervention. There was no evidence that prone or mechanical restraints other than protective restraints were in use at the facility. Staff interviewed were aware of the mandates prohibiting the use of prone and mechanical restraints. Staff indicated that if, during a horizontal restraint, the individual moved into a prone position (i.e., if it was not possible to prevent the individual from moving into a prone position), the individual would be immediately released from the restraint. Documentation reviewed for one restraint incident during which this occurred (Case #43119 on 02/13/10) noted that the supervisor instructed staff to immediately release the individual from the restraint when the individual's position could not be corrected.	

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		DADS and facility policies mandated that restraints may only be used if the individual posed an immediate and serious risk of harm to himself, herself, or others in item IV.C.1.a, and after a graduated range of less restrictive measures in item VI.C1.b. Item IV.C.1.d stated that restraints would not be used as punishment, for convenience of staff or in the absence of or, as an alternative to treatment. The DADS policy outlined when and how restraints were to be used and described procedures that staff must follow regarding monitoring and documentation of restraint use. These policies were in line with the contents of this provision. A majority of the Restraint Checklists reviewed indicated that restraint was applied after verbal redirection was found to be ineffective. There was little indication that a graduated range of less restrictive measures had been exhausted prior to the implementation of restraint.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	DADS policy item VI.F.1 mandated that restraints be terminated as soon as the individual was no longer a danger to himself, herself, or others. The policy stated that the maximum time an individual may be restrained for crisis intervention prior to attempting release is 30 minutes. From the sample reviewed, there were three incidents where restraints were applied for more than 30 minutes. These three were: • 2/22/10, duration 33 minutes, • 1/28/10, duration 35 minutes, and • 11/12/09, duration 34 minutes. There was no indication that attempts were made to release the individual within the required 30 minutes. Although the duration of restraint did not exceed the maximum by more than a few minutes, reasons for the extension were not indicated in any of the documentation for these three restraints. Overall, however, restraints at MSSLC were implemented for relatively brief periods of time. From the sample of 62 physical restraint used for crisis intervention , checklists documenting these restraints showed: • 30 restraints were for five minutes or less, • 21 restraints were between five and ten minutes in duration, and • 11 restraints lasted over 10 minutes. Restraint checklist and Restraint Debriefing, Review, and Face-to-Face Assessments completed for each incident of restraint indicated that restraints were terminated as soon as the individual was no longer a danger to himself, herself, or others.	

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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.	Prevention and Management of Aggressive Behavior (PMAB) was used at all facilities across the state and was the specific training program identified in the state and facility policy. The policy described the types of restraints that were allowed to be used and listed restraint types that were specifically prohibited. There was no evidence that any prohibited restraints had been used during the period reviewed. The policy addressed staff training mandates regarding the use of restraints. Policies required that, before working with individuals, all staff responsible for applying restraint techniques have to successfully complete competency-based training on approved verbal intervention and redirection techniques, approved restraint techniques, and adequate supervision to any individual in restraint. Staff were required to complete initial training and were retrained at least annually on the use of restraints. This training included RES0105 Restraint: Prevention and Rules for Use of Restraints at MR Facilities, RES0110 Applying Restraint Devices, and Competency Based PMAB training. Training transcripts were reviewed for five employees and confirmed that four of the five had completed all three training modules within the past 12 months. One direct care professional in the sample had not completed RES0105 or RES0110 within the past 12 months. A larger sample of employee training records will be reviewed in upcoming monitoring visits. Informal interviews with staff confirmed a basic knowledge of policies regarding restraint, including prohibited restraints and required documentation and follow-up. When direct care professional staff were questioned about what they do if an individual begins engaging in aggressive behavior, direct care professionals were able to describe a limited number of strategies or redirection approaches to managing the behavior. Staff, however, were not always familiar with strategies contained in specific PBSPs for deescalating aggressive behaviors. Staff reported that they were comfortable in seeking additional information from psychology staff assigned to their work area and, furthermore, staff indicated that psychology support staff was readily available and helpful when they needed additional support. Homes with the highest number of behavioral incidents had a psychology support staff person assigned to work at each of those homes with an office located at the home. It was observed during the on-site review that psychology staff were on the floor, available, and involved with individuals and their direct care professional staff. Direct care professional staff indicated that campus auxiliary staff was available during evening and weekend hours and responded quickly to provide back up support if a behavioral crisis occurred.	
C4	Commencing within six months of	MSSLC's restraint policy only addressed the use of restraints as crisis intervention. The	

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	the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	policy stated that restraints may only be used for crisis intervention or medical reasons. There was no indication that restraints had been used at the facility other than for crisis intervention or medical reasons. As required by MSSLC policy, safety plans were in place to guide staff in using restraints for crisis intervention for those individuals where restraints had been used three or more times in any 30 day period. The facility had a Human Rights Committee chaired by the facility Ombudsman. The committee met to review restraint incidents, as well as other rights restrictions. At the committee meeting observed during the monitoring visit on 3/23/10, the chair presented a brief summary of restraints used during the month of March. There was no discussion or recommendations by the committee regarding any of the restraint incidents presented. Although not the responsibility of the HRC, further discussion of restraint incidents by the HRC might prompt recommendations from the committee for restraint reduction strategies that would be beneficial for PSTs to consider implementing. Individual PSPs clearly stated when a particular type of restraint could not be used with an individual due to medical orders. For example, the PSP for Individual #63 stated that "restraints are not allowed due to a diagnosis of scoliosis." It was observed in Whiterock, that there was a list posted of individuals who could not be restrained horizontally due to medical conditions. Staff interviewed were aware of the list and familiar with the names on the posted list. There was little evidence found that medical or dental restraints were routinely used or that their use was considered to be an acceptable practice. Although the facility lacked a formal plan for reducing the use of medical and dental restraints, it was evident that there was an interdisciplinary effort to reduce the use of medical and, in particular, dental restraints. The dental clinic focused on desensitization strategies that are likely to be effective in reducing restraints. Some of these strategies included scheduling multiple short visits when dental work was needed, taking extra time to allow patients to become comfortable at the dental clinic, taking breaks during procedures, and scheduling visits for noninvasive work prior to more invasive procedures (see below). DADS should consider the use of some of these procedures at other facilities. During the Human Rights Committee (HRC) meeting observed during the on-site monitoring visit, medical and dental restraints were reviewed. The committee discussed methods that had been attempted to eliminate the use of restraints for each individual. • One example of where desensitization strategies were being implemented to reduce the use of dental restraints, but there was not a formal desensitization plan in place, was for an individual living in Shamrock 3B. The dentist began all visits without the use of restraints. A familiar person stayed with the individual	

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		during visits and gently held the individual's hand during procedures. Several short visits had been scheduled to complete dental work and the individual was given frequent breaks to sit up and move around during the procedure. • The PSP for Individual # 502 stated that "….had started refusing to come into the clinic area. A monthly program to reacquaint him to the less threatening aspects of a dental appointment was initiated. The hygienists started brushing his teeth in the waiting area." The monitoring team heard of many instances throughout the monitoring visit where similar strategies were being implemented to reduce the use of dental restraints. The monitoring team commends these efforts. Desensitization strategies that were being implemented with individuals should be in a written plan, so that the team can evaluate what is working and make modifications if necessary to further reduce the use of restraints. During upcoming monitoring visits, the use of medical and dental restraints, and procedures to reduce or eliminate their use will be reviewed further.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative	DADS policy section VI.8 F mandated monitoring of restraints by a health care professional within the guidelines of this provision. Restraints were to be monitored with a face-to-face assessment of individuals within 15 minutes of the application of any restraint. Staff were required to complete a Restraint Debriefing, Review, and Face-to-Face form for each incident of restraint applied for crisis intervention. The policy, additionally, addressed monitoring of individuals following restraints applied away from the facility with provisions of this agreement. Mandates met this provision of the Settlement Agreement. A sample of 10 Restraint Debriefing, Review, and Face-to-Face forms were reviewed by the monitoring team. The facility had a system in place to complete these forms electronically. Of the 10 forms reviewed, four of the forms (40%) indicated that the health care professional did not monitor and document the mental status of the individual as required. All of the forms indicated that a nurse reviewed the individual's vital signs following restraint. All Restraint Checklists reviewed included an attempt by the nurse to assess the individual for vital signs and mental status following the restraint incident. Most attempts were made within 15 minutes of release from the restraint. There were three incidents where the assessment was delayed significantly. • Individual # 295 dated 7/22/09 was not assessed until 75 minutes after release,	

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	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.	• Individual #154 dated 8/14/09 was assessed 90 minutes after release, and • Individual # 488 dated 9/1/09 was not assessed by a nurse until the following day. Nine instances were documented on the Restraint Checklist of the individual's refusal to have vital signs checked by the nurse. There was no indication that a second attempt was made by the nurse to check the individuals' vital signs. The facility needs to insure that a health care professional does a face-to-face assessment of each individual as soon as possible following release from restraints. When an individual refuses assessment, the health care professional should attempt another assessment after allowing the individual time to calm.	
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.	The facility had a Restraint Checklist and Face-to-Face Assessment, Debriefing, and Review checklist for use when restraint was applied for crisis intervention. This form included a check for restraint related injuries. Facility policy addressed safety and supervision during restraint. This policy met the standards of this provision. One-to-one supervision during physical restraint and following medical or chemical restraints was documented in all incidents reviewed. Individuals received a face-to-face assessment by nursing staff following restraint use. Restraint related injuries were reviewed by nursing staff and documented. The facility tracked restraint related injuries, but there was no indication that prevention of restraint related injuries was being addressed by the facility. There had been 56 restraint related injuries at the facility since July 2009. It was unclear if these injuries had occurred as a result of the restraint or during the incident that precipitated the use of restraint. If injuries are occurring this frequently during restraint, the facility needs to identify any possible trends in individual, staff, or restraint type used and address trends through retraining in restraint use if indicated.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three	The facility policy addressed this section of the Settlement Agreement requiring the Personal Support Team (PST) to develop and implement a Positive Behavior Support Plan and a Safety Plan for Crisis Intervention for any individual placed in restraint, other than medical/dental restraint, more than three times in any thirty day period. Additionally, the	

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	times in any rolling thirty day period, the individual's treatment team shall:	PST was required to review restraints and document items C7.a – C7.g in a Personal Support Plan Addendum. The adequacy of the assessment process for any individuals who have been placed in restraint more than three times in any rolling 30-day period will be reviewed during upcoming monitoring visits. Informal interviews with direct care professionals and review of restraint documentation and Positive Behavior Support Plans revealed that staff did not have adequate strategies in place to ensure that restraints would only be used as a last resort intervention. The adequacy of Behavioral Assessments, Positive Behavioral Support Plans, and Crisis Intervention Plans is addressed elsewhere in this report. The facility will need to focus on behavioral assessments and recommendations to effectively reduce the number of restraints used for crisis intervention.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	See note C7 above.	
	(b) review possibly contributing environmental conditions;	See note C7 above.	
	(c) review or perform structural assessments of the behavior provoking restraints;	See note C7 above.	
	(d) review or perform functional assessments of the behavior provoking restraints;	See note C7 above.	
	(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	See note C7 above.	

#	Provision	Assessment of Status	Compliance
	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;		
	(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	See note C7 above.	
	(g) as necessary, assess and revise the PBSP.	See note C7 above.	
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 policy mandated that a review of each restraint, other than medical and dental restraint, would occur within three business days of the restraint based on the Restraint Checklist, the Restraint Debriefing Report, and, as applicable, the Chemical Restraint Consult form. The review was to occur at the Unit Incident Review Team Meeting and the Daily Incident Management Meeting. Of the 63 Restraint Checklists reviewed, only two included a signature and date of review in the section of the form designated for review. The Restraint Debriefing, Review, and Face-to-Face Assessment for Crisis Intervention form had a section (7.1) for review by the Unit Director, IMM, and DIRM. This section was not completed on any of the forms reviewed. The facility had some quality assurance procedures in place to monitor the use of restraints. It appeared that these processes focused on compliance in regards to documentation of restraints rather than restraint procedures or efforts at reducing restraints.	

Recommendations:

1. Complete behavioral assessments as often as needed to determine precipitating factors to restraint use and develop Positive Behavior Support Plans that offer direct care professionals a graduated range less restrictive interventions to manage behaviors in the least restrictive manner.

2. Psychology staff should provide individual specific training to staff on strategies for behavioral intervention and request frequent feedback from staff on which strategies are effective. Plans should be reviewed and modified when strategies are not effective in deescalating aggressive or self- injurious behavior.

3. In the process of restraint debriefing and follow up, PSTs, the Restraint Reduction Committee, and the HRC should focus more intensely on proactive measures that can reduce or eliminate the need for the use of restraints with the individual in the future.

4. Continue to focus on developing desensitization programs for individuals currently using medical and dental restraints and develop written plans to support consistent implementation of desensitization efforts.

5. Remove references to mechanical restraints for crisis intervention from all policies and restraint forms to avoid confusion on types of restraints that are permissible for use at the facility.

6. The facility needs to compile data on restraint use and trend by individual involved, staff involved, date, time and any other indicators that may be useful in developing a restraint reduction plan focused on unique trends at MSSLC.

7. The facility needs to insure that a health care professional does a face-to-face assessment of each individual as soon as possible following release from restraints. When an individual refuses assessment, the health care professional should attempt another assessment after allowing the individual to calm down.

8. Review incidents of injuries related to restraints for any trends and develop a plan of action to reduce the number of injuries due to the use of restraints.

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: ○ State Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management ○ Unusual Incident Report Coding and Reporting Matrix ○ MSSLC Client Abuse and Neglect Policy 5/6/09 ○ MSSLC Facility Incident Management Policy 1/1/10 ○ MSSLC Employment Testing, Examination, and Investigation Policy 5/1/04 ○ MSSLC Volunteer Program Policy 7/23/07 ○ MSSLC Pre-Service Training Handbook ○ MSSLC Annual Retraining Handbook ○ Abuse and Neglect ABU0100 Training Curriculum ○ List of all abuse/neglect/exploitation investigations since 7/09 ○ DFPS Investigation data and graph September 2006-Feb 2010 ○ Abuse and neglect trends FY2005-FY2010 ○ Incident trends FY2005-FY 2010 ○ Injury data and trends 9/06-3/10 ○ Abuse and Neglect Employee Reassignment Log 3/24/10 ○ Documentation of disciplinary action taken for a sample of five confirmed employee perpetrators ○ Notification from OIG regarding investigations for case #100313, #100314, #100319, and #100320 ○ List of incidents involving peer to peer aggression since 7/09 ○ List of all injuries by individual since 7/09 ○ List of all individuals who sustained a bone fracture since 7/09 ○ List of all individuals with injury requiring suture or derma bond since 7/09 ○ Daily Incident Review Team Meeting Summaries for the following time periods: • 7/20/09-7/24/09 • 9/21/09-9/25/09 • 12/14/09-12/18/09 • 2/1/10-1/5/10 ○ Training transcripts and background checks for five following employees: • Patrick Samuels, Investigator • Four DCP staff members ○ Sample of PSPs including: • Individual #331 1/6/2010 • Individual #8 12/3/09 • Individual #387 1/6/10 • Individual #502 1/5/10

	• Individual #216 3/15/10 • Individual #134 2/3/10 • Individual #101 1/12/10 • Individual #330 2/10/10 • Individual #38 3/8/10 • Individual #63 2/4/10 • Individual # 225 1/25/10 • Individual #358 1/13/10 o Sample of Closed DFPS Investigative Reports from 8/09-1/10 (19 total) • #34074769 11/11/09 Sexual Abuse Confirmed • #34798971 12/22/09 Sexual Abuse Confirmed • #35037114 1/27/10 Exploitation Referred back to facility • #35119589 2/3/10 Sexual Abuse Unconfirmed • # 34994509 1/22/10 Neglect/Fracture Referred back to facility • # 34918492 1/16/10 Emotional Abuse Confirmed • #34189269 11/20/09 Physical Abuse Confirmed • #34125289 11/16/09 Physical/Emotional Abuse Unconfirmed • #34281069 11/27/09 Physical/Emotional Abuse Unfounded • #35656989 3/22/10 Exploitation Open • #33424389 9/24/09 Neglect Confirmed • #33703451 10/12/09 Physical Abuse Confirmed • #34918672 1/17/10 Physical Abuse Unconfirmed • #34747589 12/20/09 Physical Abuse Confirmed • #34307969 11/25/09 Sexual Incident Referred back to facility • #3466249 12/23/09 Neglect Referred back to facility • #35103532 2/2/10 Physical Abuse Unconfirmed • #35136571 2/5/10 Emotional Abuse Confirmed • #34918492 1/16/10 Emotional Abuse Confirmed/Physical Abuse Unconfirmed o Three most recent injuries investigated by facility: • #100210 Serious Injury-Determined Cause 2/10/10 • #100126 Serious Injury-Determined Cause 1/26/10 • #100202 Serious Injury-Determined Cause 2/2/10 Interviews and Meetings Held: o Danny Watson, QA Auditor o Charles Bratcher, QA Director o Pat Samuels, Incident Management Coordinator o Jimmy Hansen, Facility Investigator o Donna Patterson, Facility Investigator o James Watson, Facility Investigator o Kim Kargan, QA Auditor

<u>Observations Conducted</u>:

- Whiterock Unit Morning Meeting 3/24/10
- Daily Incident Management Meeting 3/24/10
- Human Right Committee Meeting 3/23/10
- PSP meetings for Individual #230 and Individual #480
- Self Advocacy Meeting 3/25/10
- Shamrock 701, 703, and 705
- Barnett B7 and B8
- Whiterock W2, W3, W7 and W8
- Longhorn L1, L3, L4, L6
- Martin M1, M2, M4, and M6
- PAWS Program
- STEP Program
- Woodshop
- Laundry/Folding Workshop
- MISD Classroom

Facility Self-Assessment:

A facility self-assessment was not provided because this was a baseline review.

Summary of Monitor's Assessment:

MSSLC had policies in place to address identifying, reporting, and investigating incidents of abuse, neglect, and exploitation. All staff interviewed were familiar with the policies and had received training consistent with facility policies. Information regarding identifying and reporting abuse and neglect was posted in each building in the facility. There was a system in place for completing internal investigations and referring investigations to DFPS, local law enforcement, OIG, and DADS Regulatory.

The facility Incident Management Coordinator reported that there had been 1026 investigations at MSSLC in FY09, compared to 1020 in FY08. According to a log provided to the monitoring team by the facility, there were almost 600 investigations completed for abuse and neglect at the facility since July 2009. Many of those investigations involved multiple allegations. These investigations resulted in 10 confirmed cases of physical abuse, five confirmed cases of emotional/verbal abuse, 16 confirmed allegations of neglect, and one confirmed case of exploitation. Less than five percent of all allegations were confirmed in the past six months. Unique to MSSLC when compared to other DADS facilities, many allegations were reported directly to DFPS by the individuals living at the facility. Many of these allegations were found to be unconfirmed. As a result, some individuals at the facility were placed on a DFPS Frequent Caller List due to the number of allegations they reported. It appeared that all allegations were taken seriously by facility investigators and investigated in a consistent manner even when reported by an individual with a history of making false allegations.

	A review of investigations by the facility and DFPS revealed that there had been a number of serious incidents of abuse and neglect confirmed at MSSLC. This led the monitoring team to have a number of concerns. First, it is possible that additional incidents of abuse and neglect could occur, but "slip through the cracks" due to the large number of false and unconfirmed allegations made at the facility. A second concern was that the large number of investigations at MSSLC drained facility resources due to the staffing hours required to complete investigations and supplemental staff needed to replace alleged perpetrators who have been reassigned until investigations were completed. Subsequent monitoring visits will focus more on these issues and recommendations that might be helpful to the facility in addressing the problem. The facility had four full time investigators. Informal interviews with all investigators confirmed that they were all familiar with agency policies on investigation procedures and consistent in their approach to incident management. It did not appear, however, that DFPS, OIG, and local law enforcement handled all investigations consistently. There was not always a clear reason given why one of these agencies would take the lead over the others in handling investigations. The current policy stated that the facility director or Adult Protective Services supervisor can grant a written extension for an investigation because of extraordinary circumstances. A review of DFPS investigations revealed investigations where approvals for extensions were requested in some cases took over 60 days to complete. In some cases, multiple extensions were requested to extend the investigations.

#	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.	Assessment of this item required review of policies and an examination of implementation of those policies. The state policy was labeled "Protection from Harm-Abuse, Neglect, and Incident Management." It was numbered 002.1, and was dated 11/6/09. It included a number of addenda and forms, such as regarding unusual incidents, high profile incidents, and staff reporting. The facility had a policy in place titled Facility Incident Management dated 1/1/10 and a policy titled "Client Abuse and Neglect" dated 5/6/09. The policy regarding Client Abuse and Neglect clearly indicated that abuse and neglect of individuals would not be tolerated and required staff to report any abuse or neglect of individuals. All staff were required to report suspected abuse, neglect, and exploitation. There were posters regarding this mandate posted in each facility visited and all staff interviewed were able to relay this information.	
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		

#	Provision	Assessment of Status	Compliance
	incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The policy titled "Facility Incident Management" specified reporting requirements for all serious incidents and was in line with this provision. Additionally, the facility had policies in place regarding specific types of incidents, such as unauthorized departures and suicide threats. The facility policy included an Unusual Incident Reporting Matrix that served as a quick reference for determining to whom incidents should be reported, and within what time frame. The facility utilized a standardized reporting form for all serious injuries and incidents. Policies mandated that all incidence of suspected abuse, neglect, or exploitation were to be reported to DFPS within one hour. A review of investigation documentation confirmed that the facility was generally in compliance with this mandate, although, there were exceptions as noted in D.2.d below. There was documentation of compliance with reporting requirements in incident documentation reviewed by the monitoring team.	
	(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 policy mandated immediate action and reporting of all allegations of abuse, neglect, and exploitation, and any serious injuries. Initial staff inservice training included training on recognizing and reporting incidents of abuse and neglect (Course ABU0100) that was to be provided upon initial hire and annually for tenured staff. Staff interviews confirmed that staff were aware of the mandate to immediately protect the victim from further harm. Further, facility staff appeared to take immediate and appropriate action to protect individuals involved. Observation of facility Incident Management Meetings confirmed that participants discussed each incident and made recommendations to further protect the individual if warranted by removing alleged perpetrators, increasing staffing ratios, or requesting other additional supports as needed. In all cases reviewed, a nurse completed an immediate assessment of the individual and recorded findings on a standardized Client Injury Report Form. The policy addressed the reassigning of alleged perpetrators. It was evident that alleged perpetrators were routinely reassigned until investigations were completed. The MSSLC policy requires that alleged perpetrators remain on reassignment until DFPS had contacted the Risk Manager with clearance of the alleged perpetrator from the	

#	Provision	Assessment of Status	Compliance
		investigation. A review of Incident Management Meeting minutes indicated that employees remained on reassignment until investigations were completed. This presented a unique challenge for MSSLC administrators due to the large number of allegations at any given time. Facility investigators reported that it was not unusual to have 30 to 40 staff reassigned at any time due to allegations. A review of the Abuse and Neglect Employee Reassignment Log confirmed this. For example, on 3/23/10, eighteen Whiterock direct support professionals were reassigned as the result of allegations from one Whiterock resident. This particular resident had a frequent history of making blanket allegations regarding abuse by staff. DFPS had developed a Frequent Caller List of individuals who frequently reported abuse and neglect. MSSLC had developed a policy to address this specific situation. The policy stated "For clients who are on DFPS' Frequent Caller List AND who have falsely accusing others (FAO) addressed in their Behavior Support Plan (BSP), it is not a requirement to automatically take the alleged perpetrator (AP) out of client contact. The AP could be reassigned, under supervision, to another home. If the AP is reassigned, an HLT-14, Investigation to Justify Placing AP in a Client Contact Position, will be completed. CAUTION: However, even if a client is on the DFPS Frequent Caller List and FAO is part of their BSP, it is still necessary to examine the circumstances of the allegation carefully before determining the AP can remain in client contact." The monitoring team did not find evidence of this policy being implemented. It appeared that the facility reassigned APs involved in investigations to positions excluding individual contact regardless of whether or not FAO was addressed in the individual's BSP. An obvious concern that arose from this situation was how the facility continued to provide the staff necessary to provide adequate support services with staff trained to work with each individual. Facility administrators and home managers agreed that this was an ongoing challenge, but one the facility continued to focus on and address. The monitoring team noted that the facility and DADS might take some actions, such as: • Explore what other facilities around the country and state have done to address this problem, including facilities for individuals with developmental disabilities, as well as facilities for individuals with psychiatric disorders and correctional facilities. • Consider this a special project for the QA department to oversee, including the initiation of a formal performance improvement project. • Interview and involve direct care professionals and managers from the	

#	Provision	Assessment of Status	Compliance
		Whiterock and Longhorn units. They had daily experience with the individuals and may be able to provide insight and suggestions. Numerous entries in the facility's suggestion box asked for help with this challenging issue. A sample of documentation of employee disciplinary action was reviewed by the monitoring team for four incidents where abuse or neglect was confirmed. Disciplinary action was taken by the facility in each of the four cases following notification by DFPS that the allegations were confirmed. The following is a summary of action taken in regards to those four confirmed allegations. All four cases were resolved within the timeline required by policy. OIG had opened cases on all four allegations to pursue criminal charges. The outcome of those cases are unknown.	
	(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 facility provided initial training and annual retraining on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation. Documentation of training was kept by the facility and a small sample was reviewed. Training transcripts for the employees interviewed showed that all had received required training on abuse and neglect within the past year. During interviews, all employees were able to give accurate examples of abuse and neglect and verbalized their responsibility for reporting such incidents. A larger sample of training records will be reviewed for reviewing this provision item during future monitoring visits.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are	The policy addressed mandatory reporters. All staff who were interviewed were aware of their obligation to report. A sample of staff personnel records was not reviewed during this initial review to verify the existence of these signed statements regarding reporting obligations, however, this will be verified during future reviews. In all facility buildings toured during the review, posters stating the obligations of mandatory reporters were posted in common areas.	

Date	Allegation	Disciplinary Action	Date of Action Taken
10/11/09	Neglect	Termination	12/11/09
9/20/09	Physical Abuse	Termination	11/3/09
12/30/09	Physical Abuse	Resigned	1/5/10
12/31/09	Neglect	Termination	1/21/10

#	Provision	Assessment of Status	Compliance
	mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	Even so, a review of investigations at the facility revealed that staff witnessing abuse did not always report the abuse as required. • In related DFPS investigations #33424389 and #33425829 dated 9/24/09, a direct support professional witnessed physical abuse of two individuals (residents of the facility) by two coworkers. She did not report the incidents as required. The staff person who failed to report was charged with neglect in the incident, representing appropriate action by the facility. • In DFPS investigation #34189269, two direct care professionals witnessed an individual (resident of the facility) being punched in the face by a coworker. Neither staff person reported the incident as required. The incident occurred at MISD at approximately 9:50 am on 11/20/09 and was reported to DFPS at 11:46 by MISD administrative personnel. Neither witness was investigated for neglect nor was there indication that any disciplinary action was taken against either witness. Concerns were noted by the DFPS investigator that the incident was not documented in observation notes and statements by the AP indicated acceptance of his action by employees witnessing the incident. The facility administration needs to ensure that all staff are aware that the failure to report any instance of abuse or neglect will be investigated and disciplinary action will be taken if warranted.	
	(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 policy stated that a training and resource guide on recognizing and reporting abuse and neglect will be provided by the facility to all individuals and their LARs at admission and annually. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. PSPs did not document that this brochure was shared with the individual and his or her LAR (if applicable) at annual PST meetings. This item will be reviewed further at future monitoring visits. Clear reporting information was posted in each building in the facility. There were many incidents reviewed where individuals had called the 800 number or reported abuse or neglect to a staff person on campus indicating that at least some individuals knew how to report abuse and neglect.	
	(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.	All facility buildings toured had posters with a statement of individuals' rights called "You Have the Right" posted in common areas. These posters included information on reporting violation of rights. Information on the poster was clear and easy to understand, including pictures for individuals who could not read.	

#	Provision	Assessment of Status	Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Policies addressed the referring of investigations to local law enforcement officials when a criminal act had occurred. The Incident Management Coordinator reported that facility investigators had a good working relationship with local law enforcement. Law enforcement had assigned officers to specifically work with investigations at the facility. There did appear to be some confusion around whether local law enforcement, OIG, or DFPS would take the lead in criminal allegations. Cases were routinely reported to law enforcement or OIG, but rarely both. From a sample of 14 cases involving criminal allegations, according to investigation documentation, local law enforcement was notified in four of the cases and OIG was notified in 13 of the cases. Local law enforcement was notified solely in the one case where OIG was not notified. It was not clear what factors precipitated the notification of local law enforcement. When interviewed in regards to procedures for notifying local law enforcement and OIG, the Incident Management Coordinator stated that he follows up to make sure reports are sent by DFPS to law enforcement officials. If law enforcement had not been notified by DFPS, he called or emailed notifications regarding the incident. He agreed that there was confusion over which entity would handle criminal investigations. He also reported that criminal investigations were not consistently considered for investigation by either department. The monitoring team found evidence of this inconsistency in emails summarized below from OIG. • #100313 Client was hit by unknown AP on left side of face and ribs. Submitted to OIG by facility. OIG response: "OIG-Internal Affairs will not open a criminal investigation on this allegation as probable cause can not be determined within 24 hours. It appears better suited for administrative investigation by DFPS." • #100314 Client stated that AP threw him up against the wall and punched him. Submitted to OIG by facility. OIG response: "OIG-Internal Affairs will not open a criminal investigation on this allegation as probable cause can not be determined within 24 hours. It appears better suited for administrative investigation by DFPS." • #100319 Reporter observed staff beating unknown clients, unknown time, unknown date, and unknown AP. Also, the report alleged that unknown AP(s) had brought alcohol and drugs to MSSLC and gave to clients on unknown dates. Submitted to OIG by facility. OIG response: "OIG-Internal Affairs will be handling this as a criminal allegation." Similarly, DFPS investigation # 34994509 was referred back to facility because "The allegation does not meet this Agency's (DFPS') definition of neglect because the Agency (DFPS) does not investigate injuries of unknown origin." The case involved a fractured hand due to unknown cause. According to DADS policy, this would be an incident that	

#	Provision	Assessment of Status	Compliance
		would require notification to DFPS due to possible abuse or neglect if there was medical determination of a possibility of abuse or neglect. DADS needs to work with OIG and local law enforcement agencies to determine which entity will take the lead in criminal investigations and ensure that all reported incidents of criminal activity are followed up on and investigated in a consistent manner.	
	(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.	Policies prohibited retaliatory action for reports of an allegation of abuse or neglect. The policy specified how to report retaliatory action and stated that employees engaging in retaliatory action were subject to employee disciplinary procedures. All staff interviewed stated that they were not hesitant to report suspected abuse, neglect, or mistreatment, and were able to state to whom incidents of abuse, neglect, and mistreatment should be reported.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	There did not appear to be an audit process in place to determine whether or not significant injuries were reported for investigation. A review of documentation of serious injuries supported that they were routinely reported for investigation, but this was confirmed by looking at individual reports. According to the facility investigators, all serious injuries were investigated by the facility investigators and then referred to DFPS or DADS as required.	
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		

#	Provision	Assessment of Status	Compliance
	involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The state policy addressed the conduct of investigations and qualifications of investigators. The policy stated that all investigators who were responsible for completing all or part of the Unusual Incident Report must complete the course, Comprehensive Investigator Training (CIT0100) within one month of employment or assignment as an investigator, and prior to completing an Unusual Incident Report. Additionally, the Incident Management Coordinator and Primary Investigator(s) must complete the Labor Relations Alternative's (LRA) Fundamentals of Investigations training (INV0100) within six months of employment. A review of the training transcript for the lead facility investigator revealed that he had completed the state required trainings. Training transcripts for the other three facility investigators were not reviewed during this baseline visit. When interviewed, all of the facility investigators, however, were knowledgeable about the investigation process and requirements. Having several trained investigators on campus ensured that investigations could begin promptly.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The facility policy mandated that staff were required to cooperate with DFPS and law enforcement agencies in conducting investigations. There was no evidence that staff had not cooperated with investigations by outside agencies. Interview with the facility investigator, and review of a sample of completed investigations indicated investigations were a cooperative effort with DFPS investigators. All four of the facility investigators were interviewed and were able to describe incident types and the process for reporting to DFPS, OIG, local law enforcement and DADS regulatory.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	It was evident in documentation that the facility investigators completed preliminary steps to ensure the safety of the individual (e.g., medical evaluations and removing APs), then allowed appropriate entities to complete investigations as necessary. The facility investigator stated that the facility had a good working relationship with local law enforcement agencies and OIG and worked cooperatively with them. There was no evidence that this was not the case.	
	(d) Provide for the safeguarding of evidence.	The facility policy described procedures for safeguarding evidence in the event of a serious incident. Some DFPS investigations were not completed in a timely manner (see below) leading to questions of whether or not investigators were able to gather all evidence while it was still available, or if reports were delayed because evidence was not available (however, see data on sample below).	
	(e) Require that each investigation	The policy addressed timelines for investigations. The state policy required that	

#	Provision	Assessment of Status	Compliance
	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.	investigations commence within 24 hours, but allowed for investigations to be completed within 14 days (10 days after June 1, 2010). All investigations handled by facility investigators commenced within 24 hours of notification and were completed within ten days of the incident. Investigations by DFPS commenced within 24 hours of notification for all incidents reviewed, but were not typically completed within 10 days. A sample of 10 DFPS investigations reviewed for timeliness revealed the following: • None of the investigations in the sample were completed by the 10th day, • 50% were completed within 15 days, and • 50% were completed well after the required timeline (#35103532 23 days, #33703451 24 days, #34125289 28 days, #34798971 70 days, and #34074769 77 days). It was noted that extensions were filed for all five incidents completed after 15 days, but there was no justification included in the investigative report, therefore, the reason for the delay was unknown to the monitoring team. All investigations reviewed included a summary of the investigation, findings, and recommendations for corrective action.	
	(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	The policy mandated consistent investigation procedures and recordkeeping including elements listed in this provision item. All items listed in this provision item were included in each of the investigations reviewed both by the facility and by DFPS. Investigation files were consistently compiled in a clear and easy to follow format.	

#	Provision	Assessment of Status	Compliance
	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.		
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	MSSLC policy mandated that a Preliminary Incident Investigation report be submitted to the Facility Director who must then approve or disapprove and return it to the Facility Incident Management Investigator. If disapproved, corrective action must be taken and then the report resubmitted. The Incident Management Coordinator was required to maintain a notification log to be forwarded to the Facility Director and other designated staff by 9:00 am each working day. The final report for facility incidents requiring investigation was to be approved by the Facility Incident Management Committee within four working days of the initial report for incidents reported to DADS or within five working days of the initial report for incidents not reported to DADS. Additionally, the policy required that a summary of the investigation be sent to DADS regulatory within five working days of the incident and a final DFPS report be submitted within 14 working days for review by DADS regulatory. If the DFPS final report had not been received by the facility within 14 days, the investigator was required to send a memo to DADS denoting that the report was delayed from DFPS. It was noted that final reports were not consistently reviewed and approved by the Incident Management Coordinator/ Designee and the Facility Director/Designee in a timely manner. See chart below for specific examples:	

Incident #	Date of Final Report	IMC/Designee Signature	Facility Director/ Designee Signature
100127	1/29/10	2/25/10	2/25/10
100108	Not indicated	No signature	No signature
090111	1/27/10	No signature	No signature
100205	2/18/10	No signature	No signature
091012	11/4/09	No signature	No signature
091120	12/4/09	No signature	1/14/10

#	Provision	Assessment of Status	Compliance
		DADS reported to the monitoring team that a new process was for investigations to be signed by both the Incident Management Coordinator and the Facility Director, and that the copies provided to the monitoring team may have been generated from an electronic file without signatures, or, perhaps, were not the finalized reports. Either way, the monitoring team will look at this area during the next on-site monitoring tour.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	Each written report of unusual incidents was written in a clear and consistent manner. Reports included an in depth summary of investigative procedures, relevant history, personal information about the individual, a list of immediate corrective actions to be taken, and an analysis of findings and recommendations for remedial action to be taken.	
	(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.	It was evident that the facility followed up on individual incidents by immediately removing APs from contact with individuals, taking disciplinary action when warranted, and holding PST meetings to review incidents and take corrective action as needed. Corrective action was discussed and reviewed at daily incident management meetings. As noted above, it was not evident that the facility reviewed data for trends and took corrective action for systematic issues.	
	(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.	A review of investigation records from the past year confirmed that files were maintained and were easily accessible for review. Each investigative report included a log of incidents for the individual and another log of incidents for the perpetrator.	
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	The facility was able to provide the monitoring team with multiple logs of injuries and other incidents as requested. It was not evident that the facility used this data in any type of overall trending report to assist in quality enhancement activities. The Incident Management Committee should review not only current incidents occurring at the facility, but also review trends for system issues that the facility may need to address with a plan of correction. For instance, data provided to the monitoring team indicated that there had been 188	

#	Provision	Assessment of Status	Compliance
	incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	injuries due to falls/trips/slips at MSSLC since 7/09. This represented a significant trend that should be further reviewed. The facility should look at location, time, date and other factors to identify trends that may be contributing to this number. A plan of correction should be implemented with a goal of reducing the number of injuries. Similarly, there had been 11 injuries due to transferring/lifting. The committee should again look at these injury incidents and determine if there are any trends that can be identified and corrected. In this case, additional staff training on transferring and lifting may be warranted.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	Criminal background checks were reviewed for the four current employees. Background checks were in place for all four employees. These appeared to be routine for newly hired staff. Employees were also required to complete a form disclosing all arrests, indictments, and convictions immediately upon employment. A sample of this form was reviewed. A criminal history check log provided to the monitoring team included the names of four volunteers indicating that the facility completes background checks on volunteers, as well. Additional review of this system for both employees and volunteers will occur during future monitoring visits.	

Recommendations:

1. The state needs to collaborate with OIG and local law enforcement agencies to determine which entity will take the lead in criminal investigations and ensure that all reported incidents of criminal activity are followed up on and investigated in a consistent manner.

2. All completed investigations should be reviewed and approved by the Incident Management Coordinator and Facility Director or their designee in a timely manner as evidenced by their signature on completed reports.

3. DADS should address the trend of lengthy delays in DFPS completing investigations with the local DFPS agency.

4. Implement an audit process to determine whether or not significant injuries were reported for investigation.

5. Ensure that all staff are aware that the failure to report any instance of abuse or neglect will be investigated and disciplinary action will be taken if warranted.

6. Data gathered on incident and injury trends should be analyzed and a summary of findings should be used to develop specific objectives in the facility's quality improvement plan.

7. Ensure all individuals and their LARs receive the annually required information regarding abuse and neglect.

8. Continue to take every allegation of abuse seriously. Take steps to address the occurrences of false accusations. Some suggestions were detailed above (please see above in D2b) and included:
    a. Explore what has been done at other facilities around the country and state,
    b. Focus on this problem via a QA or program improvement project.
    c. Involve staff and individuals in coming up with possible solutions.

<table>
<tr><th>SECTION E: Quality Assurance</th><th></th></tr>
<tr><td>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:</td><td>Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o DADS policy #003: Quality Enhancement, dated 11/13/09
o MSSLC policy and procedure manuals
• Brown: organizational
• Green: campus
• Blue: home life and training
o MSSLC policy: Quality services management division, dated 6/15/06
o Organizational chart, dated 2/23/10
o List of meetings
o QE Plan
o QA monitoring table (showing who was responsible for what QA activities)
o Set of review tools used to review aspects of each of the Settlement Agreement Provisions
• Tables showing the results for most, but not all, of the above reviews. Some, but not all, showed data from November 2009 through February 2010.
• Total Compliance by the Month Summary 2010 table that showed a summary of all data for all of these tools in one document, and that showed data from November 2009 through February 2010.
o Review tool to review aspects of PSP meetings
o Review tool to review aspects of ICFMR CMS regulatory requirements
• Table called the QA trending report for September 2009 through February 2010 that showed data for the above reviews
o Four graphs with accompanying data tables for data from September 2006 through February 2010 and a paragraph providing some explanatory information
• DFPS investigations
• Confirmations of allegations
• Reported injuries
• Restraint usage, both program and emergency
o Notes and reports addressing five different areas related to the activities of the QA and risk management departments
o Answers to Monitor's questions, 3/23/10
o Suggestion box comments, 7/1/09-3/23/10
o Survey of organizational excellence, Mexia State School, March 2008
o Performance evaluation team (PET) procedures, dated 10/15/09
o PET meeting notes:
• Group 1: 11/4/09, 1/7/10, 2/18/10, 3/4/10
• Group 2: 12/2/09, 1/14/10, 2/11/10, 3/11/10
• Group 3: 12/10/09, 2/4/10, 3/18/10
o Performance Improvement Council (PIC) procedures, dated 10/15/09</td></tr>
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PIC meeting notes: 11/3/09, 12/15/09, 1/5/10, 1/26/10, 2/3/10, 2/17/10, 3/3/10, 3/17/10
MSSLC plan of improvement, August 2009

<u>Interviews and Meetings Held</u>:

Debrah Burgess, Director of Quality Assurance
Etta Jenkins, Settlement Agreement Coordinator
Julie Moy, MD, MPH, DADS Medical Director
Lynda Mitchell, Facility Ombudsman and Rights Officer
Individual interviews with six individuals, representing all five units

<u>Observations Conducted</u>:

Facility Management Meeting
Self-advocacy Meeting

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Facility Self-Assessment:

A facility self-assessment was not provided because this was a baseline review.
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Summary of Monitor’s Assessment:

MSSLC had initiated a number of activities in the development of a quality assurance program. The Quality Assurance Department was headed by Debrah Burgess and she worked with the assistance of many staff and alongside Etta Jenkins, the facility’s Settlement Agreement Coordinator. Ms. Burgess and Ms. Jenkins were extremely knowledgeable about the facility’s quality assurance operations. They readily answered the monitoring team’s many questions and numerous requests for documents, meetings, interviews, and tours throughout campus and throughout the day and evening.

The facility implemented many portions of the state’s new policy on Quality Enhancement. This included plans of improvement, data collection, and the formation and regular meetings of Performance Enhancement Teams and the Performance Improvement Council. The documents reviewed and interviews conducted indicated that the facility was considering quality assurance and the Settlement Agreement very seriously as evidenced by the amount of time and resources devoted to data collection, documents, and meetings.

Therefore, it is expected that the quality assurance program will develop and mature over the next few years at MSSLC. Improvements and developments will be needed in the breadth of the quality assurance activities, the validity and reliability of the department’s data collection activities, the thoroughness of the QE Plan, the use of graphic presentations, and the writing and disseminating of a regularly produced quality assurance report. Other comments are detailed below in this section of the report.

The monitoring team looks forward to continued development of MSSLC’s quality assurance program.
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#	Provision	Assessment of Status	Compliance
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.	A review of this section of the Settlement Agreement required the monitoring team to look at policy, processes, and outcomes related to quality assurance activities at MSSLC. A policy was developed by DADS regarding quality assurance and was titled "Quality Enhancement." It was labeled policy #003 and was dated 11/13/09. The facility had adopted this policy in full. The policy called for a quality assurance system that, if implemented, would meet the requirements of this provision of the Settlement Agreement. The policy had a number of addenda and forms that were to be used for the QE plan, corrective action plans, tracking of these plans, and operation of the performance improvement council. MSSLC had numerous policies and procedures. Three binders, labeled Organizational (brown), Campus (green), and Home Life and Training (blue) contained all of these policies and procedures. Newer policies and procedures, however, had been developed and distributed by DADS for implementation at all facilities. Thus, many of MSSLC's policies were still active even though new policies had been developed (e.g., MSSLC's Internal Audits policy dated 11/15/06). Further, the content of some of the policies appeared similar, if not identical, to the state policies, but the dates of the facility policies were earlier than the state policies. Thus, MSSLC needs to ensure its policies are in line and up to date with all new state policies. Further, if MSSLC is going to have a policy that differs from state policy, there needs to be some documentation of approval by DADS central office. Overall, MSSLC had made a lot of progress and was engaged in a number of activities towards meeting the items in this provision. Many QA activities began in November 2009 and, as a result, the facility had some experience with QA activities and had obtained data for the four-month period ending in February 2010. The facility, however, was still at the initial stages of development and implementation of the overall QA process and, as noted below, many aspects of this process, as required by the Settlement Agreement and by DADS policy, were not yet in place. <u>QA Department</u> Debrah Burgess was the head of the QA department. She was knowledgeable about the specific activities of the department. Etta Jenkins, the Settlement Agreement Coordinator, also played a large role in the QA processes at the facility. Both of these facility staff were extremely helpful to the monitoring team, including obtaining documents, arranging for interviews, and describing facility processes. The facility was fortunate to have two professional staff who were organized and knowledgeable about facility QA operations. Other members of the QA staff contributed information that is addressed in other sections of this report (e.g., nursing).	

#	Provision	Assessment of Status	Compliance
		The QA department was part of the facility's Quality Services Division. The division had 29 FTEs devoted to QA and risk management activities. Ms. Jenkins was part of the Settlement Agreement Services Division; she was one of a total of three FTEs devoted to Settlement Agreement activities that occurred before, during, and following on-site tours. QA Activities QA activities at MSSLC were grouped into three categories: Settlement Agreement, ICF/MR CMS, and PSP meetings. A one-page chart called the Quality Assurance Monitoring Table specified the auditors (QA and other staff from around the facility) and their respective responsibilities for each of these three categories of QA, including the number of individuals to sample, meetings to attend, and assigned Settlement Agreement provisions. It provided a good overview of how the department ensured that all areas of focus were covered by facility staff. The first category focused upon the provisions of the Settlement Agreement and comprised the majority of activities engaged in by the QA department. A checklist tool was developed for all of the provisions of the Settlement Agreement (except for section E, Quality Assurance). These checklist tools were detailed and, in most cases, the wording was taken directly from the Settlement Agreement. The tools, moreover, included additional topics and actions that were generated by MSSLC policy and practice, MSSLC department heads, and/or the facility's plan of improvement. After reviewing these tools, a number of comments are provided below: • The contents of the tools should line up with the monitoring team's checklist tools. This would ensure that the activities engaged in by facility managers and staff, and the actions that are monitored by QA staff, are in line with the actions of the monitoring team. The Monitors have discussed this with DADS central office staff. Of note, however, is that the monitoring team checklist tools are likely to be revised somewhat following the completion of the set of baseline reviews. • The policy called for "an integrated, reliable and valid data information system that compiles relevant individual and organizational data…" (page 2); the facility to "review and monitor the integrity and validity of the data…" (page 6); and that "data must be tracked 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." (page 7). The QA system at MSSLC was not yet meeting this requirement. These clear directives from the policy require that the QA	

#	Provision	Assessment of Status	Compliance
		department: o Ensure validity of the items in each tool (i.e., whether the tools actual measure what it is they are purporting to measure). This requires an examination of the definitions the auditor used to determine if the item was present or not. ▪ Experts in each discipline area should be involved in this process, both at the facility level, and at the state level (i.e., central office discipline heads). ▪ Some items reviewed by the auditors appeared to include a broad range of possible actions and outcomes. Therefore, a detailed definition is needed for auditors to determine the presence or absence of the indicator. One example is the contents of provision item L1. o Ensure the tools are reliable; that is, that there is agreement across auditors, that unintentional bias by auditors is reduced, and that observer drift does not occur (a change, over time, in what is accepted to indicate presence of the indicator). • The facility's process for looking at the use of restraints appeared adequate. The facility, however, needed to also have a system for identifying dental and medical restraints and developing plans to reduce those restraints (see section C above). • The QA department implemented a reasonable method for the systematic sampling of individuals across each month. The monitoring team was told that the QA department monitored 28 individuals each month to meet a goal of monitoring more than 10% of individuals each quarter year. A running list of monitored names was kept and referred to when choosing the next sample to avoid repeating a name. If a home was not included in the sample for one month, it was included the next month to ensure that all homes were included at least once during the quarter. • Some tools will need to be revised when DADS generates the state policy (e.g., sections G, H, J). • The QA system should itself be subject to review, feedback, and assessment. • The MSSLC QA director and her staff would benefit from having opportunities for training and coordination with central office DADS staff and with the QA staff from other facilities. The second category looked at a variety of areas related to ICF/MR and CMS regulations. The tool used by the QA department was a one-page checklist with 23 items in areas of engagement, home environment, individual programming, and community participation. The third category was related to PSP meetings; that is, the content and conduct of PSP	

#	Provision	Assessment of Status	Compliance
		meetings. The auditors used a four-page document that looked at all aspects of the PSP meeting, such as scheduling, participation, rights discussion, and permanency planning. • This process should be incorporated into the overall QE plan. When DADS develops and distributes its policy for Integrated Protections, Services, Treatments, and Supports (section F of the Settlement Agreement), the facility will likely revise this checklist and incorporate the PSP checklist into its QA activities for section F. The Settlement Agreement, in addition to requiring quality assurance activities for the overall compliance with the agreement, specifically required quality assurance and quality review activities in a number of provisions, including F2q, L3, T1f, and V3. The QA department head told the monitoring team that F2q, T1f, and V3 were being addressed as part of the ongoing QA monitoring activities as described above. She noted that L3 was a medical quality improvement process that was to be developed by the DADS central office sometime in the future. <u>QE Plan</u> The DADS policy required the development of a quality enhancement plan (QE Plan). MSSLC had a QE plan. It was a two-page document that followed the policy in format and content. It was presented in table format. It included a row for each Settlement Agreement provision, and columns for the person responsible (QA auditors), frequency of review (all were monthly), the audit tools to use (briefly listed), sample size (three percent), the responsible person to aggregate data and generate reports (QA staff), when results would be reviewed (at PET and PIC meetings), who will interpret and analyze results (PET), who will make recommendations (PIC), who will receive the recommendations (department heads), and who will oversee any changes (QA auditors). The policy required a minimal number of operating committees to be in operation at the facility. The policy listed restraint reduction, human rights, health status, incident management, behavior support committee, pharmacy and therapeutics, infection control, and skin integrity. All of these were in operation (or were soon to be in operation) at MSSLC. Although the QE plan followed the DADS format, a number of comments are relevant and are presented below. • The policy called for the QE Plan to be a "document that describes the quality enhancement system in terms of the organizational structure, functional responsibilities of management and staff, lines of authority, and required interfaces for those planning, implementing, assessing, monitoring, and improving all activities conducted." The plan, however, only addressed the Settlement Agreement provision items C through V. The QE plan did not have	

#	Provision	Assessment of Status	Compliance
		any narrative describing its purpose, how the content was determined, what areas were of importance to the facility, and so forth. It did not address the content of this paragraph from the policy. • The policy, on page 4, called for quality planning at the facility to include the following items (a) degree of risk, (b) quality of life initiative, (c) DOJ Settlement Agreement compliance, (d) compliance with federal and state law, rules, and regulations, and (e) reducing unwanted variation in process and outcomes. MSSLC's QE Plan only addressed item (c) and should address the other four components of this paragraph. • The QE plan did not include the other two categories of QA activities described above (ICF/MR regulations and PSP meetings). • The QE plan did not address the Health Care Guidelines. • A typical outcome measure usually assessed and tracked at facilities, such as MSSLC (and most agencies and companies) is the satisfaction of individuals, their families and LARS, staff, and affiliated providers (e.g., local hospital, community physicians, community employers). These groups are surveyed to assess their satisfaction across a range of areas, some broad, some very specific. The MSSLC QA program should include a regularly occurring measurement of these types of satisfaction. Moreover, this was indicated in the policy on page 3, that is, to "...assess individuals satisfaction with services and supports." o MSSLC was re-starting a self-advocacy group during the week of the on-site tour. The group was facilitated by the facility's ombudsman. She reported that the previous group had been active, but participation was severely reduced when members moved to community placements. The meeting was held in the evening at the canteen. Only one or two individuals were present when the meeting began, but after about an hour, another 15 individuals joined the group. - The ombudsman led the meeting in a supportive and facilitative manner. She began by discussing the purpose of the group and the importance of advocating for oneself. Later in the meeting, the more verbal and expressive individuals brought up questions about money management, community placement, and access to the canteen and vending machines. There was good discussion. A structured problem-solving model would be helpful for the operation of this portion of the meeting. - In addition to assessing individual satisfaction in a more structured manner, the facility should follow through on keeping self-advocacy groups active. As discussed with the ombudsman, the facility should consider having more than one self-advocacy groups because there was a great variety in individual needs, competencies, and preferences across the facility. One suggestion was to create two	

#	Provision	Assessment of Status	Compliance
		self-advocacy groups, one for the individuals who lived in Whiterock and Longhorn, and the other for the individuals who lived in the Shamrock, Martin, and Barnet. ○ Note that some sort of staff survey was done in March 2008 and was described in a document titled "Survey of Organizational Excellence, Mexia State School, March 2008." This was conducted for DADS by the University of Texas and was implemented across all facilities. It included the responses of 290 staff members from MSSLC. It lead to a one-page action plan by the facility. No further activity regarding staff satisfaction was evident over the past one and one-half years or more. Further, no activities were evident regarding the assessment of satisfaction from the other groups listed above. ○ A procedure called the "Suggestion Box" generated many anonymous suggestions from staff at all levels (and some comments from individuals, too). Often, these types of systems result in little participation by staff, but at MSSLC there appeared to be a lot of participation. Many items were submitted and they were summarized on a weekly record. The items indicated many important concerns of staff members and showed that many staff took the opportunity to inform management of issues, needs, concerns that directly related to the successful operation of services at MSSLC. Follow-up should occur and it should be monitored by senior management and the QA department. Without follow-up, staff will eventually stop submitting suggestions and will feel that their voices and concerns are not of concern to management. The facility should consider some way of reporting the suggestions and responses so that all staff are aware. Further, many of the suggestions appeared easy to address. ○ Even though the Suggestion Box system was in place, addressing overall staff satisfaction also appeared to be an important need at MSSLC. The monitoring team heard comments from numerous staff at different levels from around the facility regarding being fearful of retaliation, losing their jobs, and getting in trouble. The facility administration needs to further assess staff satisfaction and ensure staff are able to freely participate in the activities and improvements that the administration hopes to accomplish at the facility. Other Policy Requirements The policy required a program improvement committee; this was in place at MSSLC. It also required performance improvement reports. These were to be self-assessments completed on a monthly basis. MSSLC did some reporting of data to central office, but	

#	Provision	Assessment of Status	Compliance
		there was no evidence of any type of performance improvement report. The documents described below (e.g., notes from PET and PIC meetings, the data tables, and submissions of some data to central office) did not meet this requirement of a regular performance improvement report. Overall, the monitoring team was pleased to see the many actions being undertaken by the facility regarding quality assurance. The facility had a reasonable infrastructure in place to continue to make progress in this provision item.	
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.	<u>Data Collection and Management</u> MSSLC summarized and reviewed data that QA staff collected in a number of ways. First, data on each item of each review tool were collected each month and entered into a table showing the presence or absence per item for every sample unit (e.g., per individual, per meeting). Then the data were calculated into an average for the month per item and per sample unit. Then, these monthly totals were aggregated into a single percentage for the entire provision and entered into a table called Total Compliance By The Month Summary 2010. This table had one row for each Settlement Agreement provision, and one column for each month, beginning with November 2009. (The exception to this was the information from the PSP meeting review tool. These data were sent to central office and the facility did not receive any feedback on performance in this area. Following each implementation of the tool, however, the auditor provided some immediate verbal feedback to the PSP meeting participants, albeit brief.) The tabling of data was a reasonable first step to the summarization and presentation of the data and the monitoring team was pleased to see the efforts that were being put into managing all of these data submissions. Nevertheless, typical data presentation and analysis requires the data to be summarized in a graphic format. Without the presentation of data in a graphic format, it is very difficult, if not impossible, to determine trends over time. The most straightforward and most useful graphic presentation is a single-line graph for each of the provisions. The QA department should graph all of their data in this manner. The facility clearly had the capability to do this type of graphing. For example, the monitoring team was presented with single line graphs for four measures that were maintained by the department head of the Quality Behavioral Services Division. These graphs showed the monthly frequencies, since September 2006, of DFPS investigations, confirmations of allegations, reported injuries, and restraint usage (both program and emergency). It seemed that these data were managed and maintained by the department head rather than incorporated into the overall quality enhancement planning by the QA department.	

#	Provision	Assessment of Status	Compliance
		Each of these four graphs was accompanied by a table of the data used to create the graph and a short paragraph providing further information "behind" the numbers, such as a change in the reporting system for injuries. Improvements were needed in the way MSSLC summarized and analyzed data. That is, there was an absence of any type of QA narrative report. Generally accepted professional standards in quality assurance, and the state policy, required that there be some sort of report that allowed for an explanation of the data, a description of circumstances or conditions surrounding the data, reasons for changes in trends, specific individuals or programs that affected the data, recommendations for actions, and so forth (as done somewhat for each of the four line graphs as noted above). For example, the state policy, on page 3 called for the facility to "use standardized reporting and data analysis processes," and on pages 7 and 8, referred to giving "an explanation of what each measure means," examining "what contributed to the performance problem using the '5 W's and 1 H Questions," writing "a complete explanation or summary of the significance of the outcomes," and explaining "what will be done with this information to correct or improve performance." Thus, the facility needs to develop a QA narrative report to accompany the data collected. Moreover, it was not evident that the facility was using the data that were collected to identify trends and develop action plans to address (also see below). For instance, as noted in section C above, there were a high number of injuries related to restraints. These were logged, but there was no plan to address restraint related injuries. Given that the facility struggled with a high number of investigations and unconfirmed allegations, the monitoring team expected there to be a focus on ANE issues in the QA process that included the development of strategies to address these problems. As also indicated by generally accepted professional standards, and by the state policy on page 7, "Data should be assessed against predetermined performance measures or clinical indicators." The facility will need assistance from the state in determining what these predetermined measures should be. <u>Performance Evaluation Team</u> Three PETs were meeting and operating at MSSLC. Each PET was led by the Settlement Agreement Coordinator, attended by the Director of Quality Assurance, focused on a subset of Settlement Agreement provision items, and was attended by staff who had responsibility for those provision items being reviewed by that particular PET. All provision items were addressed by one of the PETs. Each PET met once per month. An agenda was developed and minutes were kept. The facility's policy on PETs, dated 10/15/09 provided a description of the purpose of the PETs, that is, for each member to report each month on the status of his or her assigned section of the Settlement	

#	Provision	Assessment of Status	Compliance
		Agreement, and for the PET to prepare a report of the status of each section to submit to the PIC at least quarterly. A review of the minutes from the PET meetings indicated a lot of discussion and attention to the many sections of the Settlement Agreement, including review of each discipline's collected data. The minutes also reported typical activities that occur when a team is newly formed, and in this case, when a set of teams begins to work towards meeting the goals of their plans of improvement. The monitoring team looks forward to reviewing subsequent minutes, following up on the PETs' activities, and attending PET meetings during future on-site tours. As indicated above, quality assurance at MSSLC should incorporate more than just the Settlement Agreement. <u>Performance Improvement Council</u> The MSSLC PIC was formed in November and had been meeting once to twice each month since then. The facility's policy on the PIC, dated 10/15/09 provided a description of the purpose of the PIC, that is, to oversee implementation of quality assurance processes, and the functioning of each PET. In addition to reviewing quality assurance related to the Settlement Agreement, the PIC was also charged with reviewing the facilities ICF/MR and other related codes and regulations. The PIC received data from the PETs in a single table showing the overall percentage score on a chart called the Total Compliance by the Month Summary 2010. The table had a row for each provision and a column for each month. The table provided only limited information (i.e., a single percentage), but the PIC meeting minutes indicated that discussion regarding many of the items was occurring. The creation of a QA report narrative as noted above will be helpful to the PIC, too. Similar to the comments above regarding the PETs, the PIC minutes contained the kind of content one would expect to find with a newly developed work group. The monitoring team looks forward to reviewing the ongoing activities of the MSSLC PIC. <u>Corrective Action Plans</u> The monitoring team was told that only one CAP had been implemented since the initiation of the quality assurance activities described throughout section E of this report. The CAP addressed the goal of having each individual go on a community trip at least once each week. The CAP was implemented prior to the state's dissemination of its new policy and therefore, not unexpectedly, the facility's processes did meet all of the requirements of this provision (e.g., dissemination, monitoring, and modification of plan). The facility addressed the need. A one-page plan of improvement action plan was	

#	Provision	Assessment of Status	Compliance
		written on 10/8/09 and a plan of improvement chart was completed. A table showing detailed data of every outing was also submitted to the monitoring team, but it was impossible to determine if progress was being made and what other steps may have been put into place. These activities, although initiated prior to the new state policy, should be transferred on to the appropriate state forms and documentation should be completed in line with the new policy. As indicated above, a line graph would be useful to the QA department for their oversight of this CAP. Four other one-page documents were submitted to the monitoring team in response to the request for any documents resulting from the implementation of quality assurance or risk management tools. These other four documents were short descriptions of potential issues and needs at the facility for: • appointing direct care staff to the employee accident review board • wearing of bathroom safety shower shoes for individuals • adding additional security officers for video surveillance • placing video cameras in outdoor areas There was no documentation indicating what action, if any, the facility took to address these topics. The monitoring team expects that additional CAPs will be initiated as a result of this baseline review and will review the implementation of those CAPs during subsequent monitoring tours.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Please see comments provided under "Corrective Action Plans" in section E2 above. The monitoring team expects that additional CAPs will be initiated as a result of this baseline review and will review the implementation of those CAPs during subsequent monitoring tours.	
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.	Please see comments provided under "Corrective Action Plans" in section E2 above. The monitoring team expects that additional CAPs will be initiated as a result of this baseline review and will review the implementation of those CAPs during subsequent monitoring tours.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Please see comments provided under "Corrective Action Plans" in section E2 above. The monitoring team expects that additional CAPs will be initiated as a result of this baseline review and will review the implementation of those CAPs during subsequent monitoring tours.	

Recommendations:

1. Update facility policies to be in line with newer state policies. If facility policies are to differ from state policies, provide documentation of approval from the state central office discipline head.

2. Line up the quality assurance review tools to be in line with the monitoring team's checklist tools. Note, however, that the monitoring team's review tools are likely to revised following the completion of the baseline reviews at all of the facilities.

3. Ensure validity of quality assurance processes.

4. Work with state office on the identification of performance indicators.

5. Ensure reliability of data collected by quality assurance auditors.

6. Subject the QA department to quality assurance review, feedback, and assessment.

7. Provide QA director and her staff with training opportunities and with opportunities to coordinate with QA departments at other facilities and with central office.

8. Incorporate non-Settlement Agreement quality assurance activities into all of the processes and programs of the QA department.

9. Develop a QE plan that meets the state policy and that includes, in addition to the contents of the current plan,:
   - a narrative,
   - all of the areas listed on page 4 of the policy, and
   - the Health Care Guidelines

10. Develop a satisfaction measure for individuals, staff, family members and LARs, and affiliated agencies and providers.

11. Follow-up, and monitor the follow-up, to items in the suggestion box.

12. Develop two separate self-advocacy groups. Add a structured problem-solving decision-making process to the self-advocacy group meetings.

13. Provide program improvement reports as per the policy.

14. Graph quality assurance data using line graphs.

15. Implement CAPs when needed, following all requirements of E2, E3, E4, and E5 above.

16. Develop a QA report that includes a summary of all activities, data, trends, and narrative that describes important points about the data.

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 MSSLC Development, Monitoring, and Revision of Person Directed Plan Process Policy 3/15/10 o Personal Support Teams PDP Process Training Curriculum 9/22/09 o DADS 2009 Your Rights in a State Supported Living Center Booklet o DADS Positive Assessment of Living Skills (PALS) o Training transcripts for the following employees: • Four DCP assistants o Intake Information and New Admission Assessments for: • Individual #277 • Individual #535 o Sample of PSPs including: • Individual #331 1/6/2010 • Individual #8 12/3/09 • Individual #387 1/6/10 • Individual #502 1/5/10 • Individual #216 3/15/10 • Individual #134 2/3/10 • Individual #101 1/12/10 • Individual #330 2/10/10 • Individual #38 3/8/10 • Individual #63 2/4/10 • Individual #401 2/9/10 • Individual # 225 1/25/10 • Individual #358 1/13/10 Interviews and Meetings Held: o Interview with Valerie McGuire, QMRP Director o Interview with Dr. Charlotte Kimmel, Director of Psychology Services o Informal interviews with various care staff, QMRPS, nursing staff, and psychology support staff in homes and day programs throughout campus o Danny Watson, QA Auditor o Charles Bratcher, QA Director o Kim Kargan, QA Auditor Observations Conducted: o Whiterock Unit Morning Meeting 3/24/10 o Daily Incident Management Meeting 3/24/10

	○ Human Right Committee Meeting 3/23/10 ○ PSP meetings for Individual #230 and Individual #480 ○ Self Advocacy Meeting 3/25/10 ○ Shamrock 701, 703, and 705 ○ Barnett B7 and B8 ○ Whiterock W2, W3, W7 and W8 ○ Longhorn L1, L3, L4, L6 ○ Martin M1, M2, M4, and M6 ○ PAWS Program ○ STEP Program ○ Woodshop ○ Laundry/Folding Workshop ○ MISD Classroom on MSSLC campus
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The facility was only in the beginning stages of addressing this provision of the Settlement Agreement and therefore most of the items in this provision were either not developed or not yet implemented thoroughly enough to allow for monitoring. The state policy #004 Protections, Services, Treatments, and Supports dated 2/15/10 was still in draft format. The facility had developed a policy entitled "Development, Monitoring, and Revision of Person Directed Plan Process" dated 3/15/10. The development of person directed plans was a clear focus of the facility PSTs and the quality assurance team. A sample of 13 PSPs were reviewed and two annual PSP meetings were observed during the monitoring visit and confirmed that there was an evolving process in developing person centered plans. The implementation dates on the 13 PSPs reviewed ranged from 12/09 to 3/10. The plans clearly showed an effort to gather information on the individual's needed supports, interests, preferences, and long-term goals. Although much of this information was included in the plan and discussed by the team at PSP meetings, outcomes resulting from planning were often not individualized to reflect the individual's preferences and stated vision. The cover page of each PSP reviewed included a list of "what's most important to the person." These lists tended to be individualized and would be a great starting point for the development of individualized outcomes, however, this information was not incorporated into prioritizing outcomes for the individuals. For example, at the annual PSP meeting for Individual #480, the team began the meeting with a discussion of what was important to her, as well as her preferences, likes, and dislikes. The team identified activities that they knew she enjoyed but stopped short of brainstorming around new activities that she might like to participate in, given what they knew about her. For example, the team identified that she liked water and

	music activities. The next logical step in this discussion, in line with person directed planning, would have been to gather input from the team, particularly the direct care professionals, on what activities staff could introduce to explore new activities and acquire new skills. For instance, would she enjoy assisting to wash dishes, swimming, or watering plants either at home or at the greenhouse? Could the staff offer new music activities that might give her the opportunity to make choices, increase social interactions, or develop additional recreational interests? The team developed a list of interests, and then moved into a discussion of her response to current programming. Team members reported that her response to programming over the past year was "good," but did not elaborate on specific responses to implementation, barriers to progress, or what the next possible step might be to gain additional skills. At the conclusion of the meeting, the team agreed to continue with basically the same outcomes chosen from a generic functional assessment rather than develop outcomes that would be meaningful to her and move her closer to achieving her identified vision for the future. The team discussed community placement for Individual #480 towards the end of the PST meeting. It would be more meaningful to discuss community placement at the beginning of the meeting and then discuss supports and skills that she would need to ensure successful placement in the community and develop a plan based on those needed supports with skill acquisition targeted towards independence in her desired setting. Her guardians/parents attended the meeting and expressed concerns regarding community placement. The QMRP acknowledged their concerns, but offered very little information to address those concerns. Instead, the QMRP attempted to move on to other areas of discussion when the parents expressed concerns. The psychologist, however, did speak up to address the parents' concerns by talking about community options and successful placements that had occurred for other individuals. Following this discussion, her parents did agree that the information was helpful and expressed a desire to further explore community options. Since community placement will be an ongoing discussion at each PSP meeting, it would benefit QMRPs to have training on how to address concerns and issues that guardians/parents might express in regards to community placement. Many PSPs offered little guidance for providing supports, while others were fairly descriptive in the range of supports that the individual was receiving. PSPs should offer a complete picture of the individual's preferences and vision for the future and describe any supports that the individual needed throughout his or her day. The plan should describe who will provide and monitor each support, how the support will be provided, and a schedule of when each support will be needed. The overall goal of the plan should be to ensure that each individual develops or maintains skills necessary to participate to the extent possible in daily activities that are meaningful to that individual. All healthcare and behavioral risks should be identified and the team should integrate recommendations from specialists into one comprehensive plan that offers clear guidance to direct support professionals responsible for implementing the plan.

#	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:	The DADS policy for this section had not been developed at the time of this on-site review. Quality Enhancement activities with regards to PSPs were in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan based on the preferences and vision of the individual. At the facility, interdisciplinary teams were called Personal Support Teams (PSTs).	
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.	PST meetings were facilitated by the PSP Coordinator whose responsibilities included keeping the group focused on an agenda and making sure all sections of the PSP were addressed. According to the facility policy, the QMRP was responsible for scheduling PST meetings and determining which disciplines would need to be represented at the meeting. The QMRPs were also responsible for obtaining assessments, coordinating, and monitoring services for the individual. Informal interviews with QMRPs during the review process revealed that they were generally aware of the range of supports and services being offered to the individuals whom they supported. The monitoring team did not focus on the adequacy of monitoring and the revising of treatments, services and supports during this baseline review. When the monitoring team has had the opportunity to evaluate the adequacy of the process for assessing individuals and developing supports, further comments will be provided. The monitoring team's understanding was that DADS was in the process of revising a policy regarding Person Directed Planning.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The facility policy stated, using the terms and titles listed below, that the following individuals must attend the PSP and Revision staffing, and serve as members of the PST: • Client • QMRP; • Psychologist (attendance was mandatory if the client has or is being recommended for a BSP); • Direct Care Personnel from the client's unit of residence; • Staff Physician (attendance is at the determination of the PST); • Psychiatrist (attendance is mandatory if anticipated changes in behavior related to psychotropic medication changes and related medication issues will be reviewed); • Licensed nurse; • Dietitian or diet technician, if applicable; • A representative from any department which has identified the client as being in	

#	Provision	Assessment of Status	Compliance
		need of its services; • A representative of any discipline who has been requested by the QMRP to attend; • For clients who are school-age, a representative of the local independent school district; • The client's family/LAR/primary correspondent, when attendance is possible; and • A representative of the MRA, when attendance is possible. Only five of the 13 PSPs reviewed in this sample included a signature sheet, so it was not possible to determine who developed a majority of plans in the sample. The following is a summary of findings regarding team member participation as recorded on the PSP signature sheet for the five PSPs that included a signature sheet: • Individual #216's PSP signature sheet included typed names, but no actual signatures and indicated that he attended his meeting and the plan was developed by a team that included residential direct support professional, QMRP, Psychologist, RN/LVN, and Master Teacher. His mother was his primary correspondent, but she was not present. He did not have an LAR. There were no other key team members not in attendance. • Individual #101's PSP signature sheet included typed names, but no actual signatures. It indicated that she attended her meeting and the plan was developed by a team that included a residential direct support professional, QMRP, RN/LVN, and Master Teacher. Her nephew was her primary correspondent, but he was not present. She did not have an LAR. There were no other key team members not in attendance. • Individual #401's PSP included a signature sheet signed by the meeting participants. The meeting was attended by the individual, QMRP, QA-QSO, Psychologist, CLOIP Program Specialist, House Manager, Dorm Staff, Master Teacher, RN Case Manager, PNMP and PSP Coordinator. There were no key team members not in attendance. • Individual #63's PSP signature sheet included typed names, but no actual signatures. It indicated that he attended his meeting. The plan was developed by a team that included residential direct support professional, QMRP, Psychologist, and Vocational Educator. His mother was his primary correspondent, but she was not present. He did not have an LAR. There were no other key team members not in attendance. • Individual #225's PSP included a signature sheet signed by the meeting participants. The meeting was attended by the individual, PSP Coordinator, QMRP, RN, Psychology staff, and DCPs. His mother was his guardian. She was not present at the meeting. This individual received educational services from	

#	Provision	Assessment of Status	Compliance
		the Mexia ISD. A representative from the school district was not at the meeting. Signature sheets should be attached to all PSPs as evidence that PSTs were meeting annually to develop PSPs in accordance with facility policies to include all significant team members in the planning and development process. The typical procedure is for signature sheets to be completed and it was possible that a clerical error resulted in the monitoring team not receiving these signature sheets. The monitoring team will look for these signature sheets during the next on-site monitoring tour. Additional efforts should be made to include family members in the planning process when possible or to seek advocates for individuals whose family members are not active participants. Direct care professionals interviewed confirmed that they attended team meetings and were given the opportunity for input into the plan both at the meeting and outside of the meeting by ongoing discussion with the QMRP regarding supports and services. All of the direct care professionals interviewed reported that if a service or support was not adequately addressing an individual's need, they could discuss it with the QMRP or other team members and that those team members would address the issue and call the team together if needed.	
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.	It was evident that a wide range of assessments were performed prior to PSP development. It was not, however, evident that these assessments were used to address barriers to each individual achieving his or her individualized vision. PALS was the functional skills assessment used by the facility and specifically named in the state policy. While this assessment offered a basic checklist of functional skills, it did not include a means of prioritizing skills based on each individual's unique preferences. This resulted in generic outcome development rather than individualized outcomes for each individual. Additional assessments were completed for each individual by specialist and clinicians. Recommendations from these assessments were included in isolated plans rather than being integrated into a comprehensive plan for providing support to each individual throughout his or her day. In review of a sample of PSPs, it was found that most assessments indicated by the individual's needs were completed and summarized in the PSP. There were some exceptions. For example, Individual #101 had a diagnosis of mature cataracts and was legally blind. The PSP did not include a recommended schedule for vision assessments or a date and recommendations from her last assessment. She received Dilantin for epilepsy and reportedly had two seizures in 2008. The last neurology consultation documented in the PSP was in 1999 and there was no information from that consultation included in the PSP.	

#	Provision	Assessment of Status	Compliance
		As noted in a number of other sections in this report, the monitoring team found the quality of some assessments to be an area of needed improvement. In order for adequate protections, supports, and services to be included in individual's PSPs, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed. Information from assessments should be included in the PSP body and used to develop supports based on the individual's preferences and needs. This provision of the Settlement Agreement will continue to be reviewed during upcoming monitoring visits.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	A majority of the PSPs reviewed did not include a summary of services and supports that the individual was receiving. PSPs should clearly address all of the supports that an individual will receive, including a description of the residential, day, medical, and therapy services, along with a schedule of when these services will be provided, where they will be provided, and what types of supports the individual will need throughout the day. A narrative section in the PSP describing the person, his or her preferences, how he or she spends the day and what supports are needed throughout the day may help the team see how services should be integrated into a lifestyle rather than looking at supports from each discipline as isolated interventions. Individual #134's and Individual #38's PSPs, in contrast to some reviewed, contained a summary of protections, services, and supports. Both plans included a description and schedule of the supports that they received and a justification for most supports. Health summaries included current assessments, results, and recommendations. There was also a list of adaptive equipment that the individual used and current medication list along with the reason prescribed for each medication. Outcomes stated where and when training would occur and how it would be documented, although documentation requirements were not specific enough to guide staff in knowing what type of information should be recorded. Training methodology for outcomes included recommendations by therapist and suggestions for carryover training at alternate sites. When comprehensive policies are in place to address PSP development, the facility needs to be sure that QMRPs receive updated training on developing plans and a system is put into place for monitoring plans to ensure all treatments and supports for each individual are addressed in each PSP.	
F1e	Develop each ISP in accordance with the Americans with	There was a lot of discussion around providing services in the least restrictive environment at MSSLC. Staff supporting the individuals referred to community	

#	Provision	Assessment of Status	Compliance
	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).	placement as a viable option for almost everyone at the facility. Many of the individuals at the facility talked about moving into the community and were aware of what their options may be in terms of moving in the near future. Community placement was discussed at both of the PST meetings observed and all PSPs reviewed included a discussion of community placement and supports that would be needed if services were provided in the community. Individuals were provided with information regarding community placement annually and most had the opportunity to visit homes in the community to serve as a reference point in decision making. There were three locked homes on campus, but there was clearly a focus on developing effective behavior support strategies in order to move individuals into less restrictive settings. Very few PSPs included a description of the individual's current day program. There was generally not consideration of community-based day programs or supported employment by the team. Although, trips were planned in the community each week, active treatment did not focus on functional learning in the community and outcomes in individual PSPs did not focus on training in the community. Observation at the various vocational programs on campus indicated that there were many individuals who had valuable job skills that would transfer well into a more integrated setting. The facility had a vocational program that offered job skill development in an array of areas. Some jobs opportunities that were unique to MSSLC were a fully functional wood workshop that offered individuals the chance to learn a range of woodworking and carpentry skills, and a thriving greenhouse that employed a few individuals on campus and taught those individuals marketable employment skills. The facility had a Human Right Committee (HRC) in place to review any restriction of rights for the individual. Observation of an HRC meeting during the monitoring visit revealed that the committee generally looked at alternatives to interventions to reduce restrictions of rights. Informal interviews with staff in various homes throughout the facility revealed that staff were aware of the rights of individuals whom they supported and there was an understanding that they were responsible for safeguarding each individual's rights. There were clear, easy to understand posters placed in all buildings observed throughout the campus regarding individual's rights.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate,	This provision will be reviewed in greater detail by the monitoring team following the implementation of newly developed facility policies to address PSP development and	

#	Provision	Assessment of Status	Compliance
	and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:	implementation.	
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;	PSPs included a table with a list of what was most important to the individual. This list was not consistently used to develop outcomes based on the individual 's preferences. Teams should use this area of the PSP to list specific things that are important for the individual and then include supports that he or she needs to maintain or increase the occurrence of those things in his or her life, and to address any barriers to occurrence. The PSPs that were reviewed typically had an outcome to participate in some community activity, but plans did not state functional learning that would take place while the individual was in the community. The focus appeared to be on community participation in specific events rather than integration into the community. Opportunities for community integration at the facility will be reviewed further during future monitoring visits.	
	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;	As discussed in the summary above, outcomes were not always related to the individual's preferences and vision. Most outcomes did not contain enough information to be observable and measurable, and plans were not consistent in addressing supports needed to achieve outcomes. The following are examples found in PSPs related to this finding. • Individual #63's PSP included the outcome, "He will increase participation in both campus and community activities." Steps that will be taken to reach desired outcome included A. Social/Leisure Activities and B. Money management. No additional information was offered that would help staff determine when this outcome would be considered complete and what supports would be needed to achieve the outcome. The action steps should be expanded to include specific criteria for determining successful completion, such as the type of participation required on his part, and the types of supports that would be provided. • Individual #216 had the exactly the same outcome and action steps as Individual #63 above. • Action steps for Individual #101 included, "continue to open both hands to be	

#	Provision	Assessment of Status	Compliance
		sanitized, continue to turn on switch to activate radio/tape recorder, and continue to touch one of three textures to make a purchase." If these three action steps were continued from the previous PSP, the team should discuss what barriers were present if the action steps were not completed and develop new strategies for implementation. On the other hand, if the action steps were continued, but criteria were met the previous year, then the team should develop action steps to move towards further independence with these tasks. Individual #101's PSP also included the same Social/Leisure action step, "Provide opportunities for trips/activities both on and of campus." Again, this action step should contain enough information that staff will know how to consistently implement it and determine when completion criteria has been met . All action steps should include information that would direct staff in how to implement the action step consistently and to determine what level of participation by the individual is needed to successfully complete each step. A majority of the plans reviewed did address barriers to living in the most integrated setting in the summary of the living options discussion	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Achievement of this provision item varied widely across the PSPs reviewed. The facility needs to put into place specific procedures for developing PSPs that integrate all protections, services, and supports that the individual needs. PSPs were developed with an apparent goal to capture each individual's needs, goals, preferences, and abilities in one document as described by each treating discipline, but there was little evidence of true integration of all services into one comprehensive plan. Plans need to include not only a list of services and supports that the individual is receiving, but also a description of how and when those supports will be implemented and monitored.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Plans did designate staff responsible for implementation of the objectives by discipline, but lacked specific methods for implementing outcomes or, in most cases, target dates for completion of outcomes. If target dates were assigned, they generally reflected an annual date based on the PSP year, rather than each individual's rate of learning.	
	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	Most ISPs reviewed did not include specific interventions, strategies, and supports individuals might have needed to achieve outcomes. See comments in section F2a2 above. Plans did not address implementing functional learning in the community. Action steps related to community outcomes were generally just a statement that the individual would have the opportunity to do an activity in the community. They did not specify how	

#	Provision	Assessment of Status	Compliance
	community settings; and	the individual would participate in the community, what type of learning would occur, and what supports would be needed. For instance, PSPs for Individuals # 8, #101, and #216, all included the outcomes "social/leisure activities." The only guidance offered for the outcome in all three PSPs was "provide opportunities for trips/activities both on and off campus. At least one off campus trip a week should be attempted." Even though each of these individuals had different interests and support needs, no further guidance was given on what type of activity would be offered or what supports might have been needed during the activity,	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	Most plans reviewed specified a method for data collection and the frequency of data collection, but did not guide staff as to what type of information should be collected. Some, but not all action plans designated who would review and monitor implementation and progress towards outcomes. Plans should specify the data that staff will record for each action step. Data collection should indicate the individual's level of participation, supports needed, and response to the activity.	
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.	The facility did not have a process to ensure coordination of all components of the PSP. See comments above regarding the lack of integration of services for individuals.	
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.	The PSPs did not provide clear information that would guide direct care professionals in providing necessary supports. See specific details and examples in F2a above.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that,	The facility will need to develop a policy that requires monitoring of PSP implementation and criteria for reviewing data and modifying plans as needed. Efficacy of all support plans should be evaluated by team members with a system that includes input from direct care professionals responsible for implementation, oversight, and monitoring by	

#	Provision	Assessment of Status	Compliance
	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.	plan developers. Monthly progress notes were completed by therapists for direct intervention (e.g., OT, PT, SLP), but as stated above, there was limited integration of these services in the PSP in the form of measurable goals. Further, specific actions regarding modification of plans were not evident and should be undertaken by PSTs. A larger sample of implementation data will be reviewed during upcoming monitoring visits and additional comments will be made regarding the monitoring and updating of PSPs.	
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.	As noted above, staff responsible for developing plans will need to be trained on new policies relating to PSP development. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised, however, there was no system in place to ensure that this occurred and there was no documentation in place to show that staff had been trained on individual plans initially or when they were updated or modified. This provision of the Settlement Agreement will continue to be reviewed in upcoming monitoring visits to determine the adequacy of training in providing team members with the skills to develop and implement comprehensive, effective plans for individuals.	

#	Provision	Assessment of Status	Compliance
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	The facility policy mandated that a PSP will be developed for individuals within 30 days of admission and revised within 365 days or as needed. All PSPs reviewed were dated within the past year. • Individual # 277 was admitted to MSSLC and a PST meeting was held on the date of admission to develop initial supports and schedule assessments. Some assessments had been completed by the time of this on-site monitoring visit and a PST meeting was scheduled for the following month to develop a PSP. • Individual #535 was admitted to MSSLC and an admission PST was held on the date of admission to develop initial supports and schedule assessments. A PST meeting was being scheduled to occur within the month. A larger sample will be reviewed for compliance with this provision during future monitoring visits.	
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.	As noted above, Quality Enhancement activities with regards to PSPs were in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.	

Recommendations:

1. Signature sheets should be attached to all PSPs as evidence that PSTs are meeting annually to develop PSPs in accordance with facility policies to include all significant team members in the planning and development process. It is possible that signature sheets were routinely being completed and were not submitted to the monitoring team. The monitoring team will review this during the next on-site monitoring tour.

2. Additional efforts should be made to include family members in the planning process when possible or to seek advocates for individuals whose family members are not active advocates.

3. Provide training to QMRPs on how to address concerns and issues that guardians/parents/LARs might express in regards to community placement.

4. Conduct comprehensive assessments that identify the individual's preferences, strengths and supports needed.

5. Continue team building efforts at the facility to foster an attitude that encourages and supports integrated services.

6. Focus on developing PSPs that address community integration that is meaningful for each individual based on his or her preferences, interests, and supports needed.

7. PSPs should include a description of all supports that the individual will receive, including a description of residential, day, medical, and therapy services, along with a schedule of when these services will be provided, where they will be provided and what types of supports the individual will need throughout the day to support participation.

8. PSP should specify the data that staff will record for each action step. Data collection should indicate the individual's level of participation, supports needed, describe response to the activity.

9. Develop a system to monitor the PSP, the implementation of services and supports, and the timely modification of plans when services and supports are not effective.

10. Develop and implement a quality assurance process for assessing whether PSPs are developed consistent with this provision.

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:** ○ Meeting and discussion with the MSSLC medical director, Dr. Dolores Erfe. ○ General discussions held with facility and department management, and with clinical, administrative, and direct care professionals throughout the week of the on-site tour. ○ Various meetings attended by monitoring team members as indicated throughout this report. ○ Review of MSSLC's Plan of Improvement, most recent received, dated August 2009.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the on-site tour to address this provision of the Settlement Agreement. As noted elsewhere in this report, meaningful integration of clinical services was not evident in most areas at the facility. Some detail is provided below in section G1.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	A plan was not in place to address this item. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision. Discussions with staff at various levels of management, clinical services, and direct care indicated that meaningful integration of clinical services was not evident. On the other hand, there was unanimity in a desire to work towards and achieve an integration of clinical services, including more communication, acceptance of input and opinion from all clinical disciplines, and notification of treatment changes to all relevant clinicians. Achieving integration will be a facility-wide process, that is, will require that all departments and all levels of staff participate. For example, even though there appeared to be some good communication and integration of clinical services appeared between psychiatry and psychology, psychology did not appear to have any influence on (or working relationship with) the staff that managed the DCPs. For example most psychologists interviewed indicated that they had a very difficult time getting DCPs to attend training, or convince administrative staff of the need for more potent	

#	Provision	Assessment of Status	Compliance
		consequences in their PBSPs. Two other examples showed a high level of activity that MSSLC demonstrated in order to work towards integration. One was the assignment of increased level of supervision, that is, the determination of whether a PST or middle manager could override a physician's order for an increase in level of supervision, and similarly, whether a physician was allowed to make this type of order. This required much discussion at the facility, including the direct involvement of the facility director. Second, individual PSP supplemental meetings were scheduled in the morning when physicians typically held their sick call hours making it impossible for them to attend. Further, invitations and announcements regarding these meeting often did not occur until late the previous day, further competing with physician's ability to attend. Again, much work was required to come up with a solution. Dr. Erfe described other activities, while acknowledging that activities towards meeting the requirements of both section G and H were in early development. She described: • regular meetings with pharmacists and psychiatrists, • weekly meetings with physicians and the hospital liaison, • quarterly drug regimen reviews, • drug utilization reviews (these were not yet initiated), and • the upcoming first pharmacy and therapeutics committee meeting. She noted that there had been no occurrences of adverse drug reactions.	
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.	A plan was not in place to address this item. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision.	

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and outcomes.

3. There was a need to do more integrated assessments, particularly in the area of risk assessment (see section I).

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:** o Meeting and discussion with the MSSLC medical director, Dr. Dolores Erfe. o General discussions held with facility and department management, and with clinical, administrative, and direct care professionals throughout the week of the on-site tour. o Various meetings attended by monitoring team members as indicated throughout this report. o Documents reviewed by all members of the monitoring team and listed in all of the sections of this report, including assessments, treatment plans, reviews, and medical and nursing records. o Review of MSSLC's Plan of Improvement, most recent received, dated August 2009. o Review of nursing annual and quarterly assessments for a 42 individuals in the sample
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the on-site tour to address this provision of the Settlement Agreement Nevertheless, across the facility, there was great desire for there to be coordinated clinical treatment, and to have that treatment contain more than just the minimum generally accepted professional standards of care as set forth in this provision. The facility, however, lacked direction in how to obtain this outcome. This was due in part to (a) the recency of attention to this provision, (b) some confusion as to who was responsible for each component and the monitoring of each component, and (c) a plan of improvement that did not provide guidance or direction regarding specific actions to be taken.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an	A plan was not in place to address this item. Further, there were problems throughout the facility regarding the completion of assessments as indicated and detailed in throughout this report. For example, psychological Evaluations were not completed for the majority of Individuals at MSSLC (see section K6), functional assessments were not completed for	

#	Provision	Assessment of Status	Compliance
	individual's status to ensure the timely detection of individuals' needs.	the majority of individuals and those that were attempted were not complete (see section K5), and PBSPs were not consistent with current ABA standards . Further, for the most part, nursing assessments met the current, generally accepted standards of professional care as defined in the Settlement Agreement and Health Care Guidelines for a population without physical and intellectual disabilities. What was missing was an understanding of the special health issues presented by a population with challenges in communication and mobility.	
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.	Nursing diagnoses varied in quality, with some individuals having issues where nursing diagnoses were not identified. For example: • Individual #501 was hospitalized for chronic, recurrent megacolon, ileus, and decreased bowel sounds. While the progress notes were generally adequate, most often the plan said, "will monitor," without specifying what was to be monitored. Vital signs were often limited to temperatures, and failed to include a full set of vital signs, which is the standard of practice. • Individual #523: The quarterly assessment for this individual did not mention three suppositories given in 1/5,8,18/10 and results for these suppositories were not documented in the progress notes provided. PRN medications were signed for on 2/1/10 and 11/25/09, but results were not noted. A PEG tube was placed on 3/15/10 but there was no nursing diagnosis that addressed the issues leading up to this invasive alternative.	
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.	Clinical interventions were not consistently appropriate nor were they based on assessment results (see sections K5 and K9 below), or modified in response to clinical indicators (see section S3 below). In a specific example, Individual #501 failed to receive metoclopramide, a medication for gastric emptying medication, on 3/1/10 for two doses because the medication was not available. On 3/6/10 she received Phenobarbital 100 mg in error.	
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.	A plan was not in place to address this across the variety of clinical disciplines at the facility. The facility did not have a way of determining if appropriate clinical indicators of efficacy of treatments were being used.	
H5	Commencing within six months of	A plan was not in place to address this item.	

#	Provision	Assessment of Status	Compliance
	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.		
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.	A plan was not in place to address this item. Even so, each clinician, as noted throughout this report, attempted to incorporate some clinical indicators into his or her treatment decisions. There was, however, no systematic manner in which this was conducted across the facility, nor any guidance from the facility regarding how this should be done, documented, and monitored. One example, however, indicated concern to the monitoring team: Individual #501 had Urinary Tract Infections (UTIs) which are associated with fecal contamination (E. coli), but care plans did not contain instructions to wipe from front to back to avoid this problem.	
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.	Policies, procedures, and guidelines were not in place regarding Section H.	

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not minimum common elements of clinical care are being provided to individuals. This will require defining minimum common elements of clinical care, creating measurable actions, and monitoring measurable outcomes.

3. Medication Administration Records should have a place to document results from PRN medications on the MAR to allow for tracking of response.

4. Nursing diagnoses need to be complete and comprehensive and reflect interdisciplinary collaboration. For example, individuals being seen by the PNMP for dysphagia and having active issues leading to invasive intervention should be monitored (e.g. #523 had a PEG tube inserted, but there was no indication that nursing considered that a nursing problem as well).

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: At Risk Individuals ○ MSSLC Health Screening and Risk Assessment Policy 9/23/09 ○ MSSLC Organizational Management Manual – Health Status Team 10/30/09 ○ DADS Health Status Team Training Curriculum March 2010 ○ DADS Risk Assessment Tools, dated 8/31/09 ○ MSSLC Log of individuals diagnosed with pneumonia since 7/09 ○ MSSLC Log of individuals with swallowing incident since 7/09 ○ MSSLC Log of ER visits since 7/09 ○ List of all injuries by individual since 7/09 ○ Client Injury Assessment for serious injuries since 10/09 ○ Hospitalization and ER hospitalization records for individuals seen in the emergency room and/or admitted to the hospital from 2/12/09 to 1/31/10 ○ List of individuals and their risk level in the following areas: • Seizures • Challenging Behaviors • Dehydration • Osteoporosis • Skin Integrity • Weight • Hypothermia • Respiratory • Medical Concerns • GI Concerns • Constipation • Cardiac • Urinary Tract Infection • Polypharmacy • Injury • Diabetes • Choking ○ Sample of PSPs including: • Individual #331 1/6/2010 • Individual #8 12/3/09 • Individual #387 1/6/10 • Individual #502 1/5/10 • Individual #216 3/15/10 • Individual #134 2/3/10

	• Individual #101 1/12/10 • Individual #330 2/10/10 • Individual #38 3/8/10 • Individual #63 2/4/10 • Individual #401 2/9/10 • Individual # 225 1/25/10 • Individual #358 1/13/10 <u>Interviews and Meetings Held</u>: o Interview with Valerie McGuire, QMRP Director o Interview with Dr. Charlotte Kimmel, Director of Psychology Services o Informal interviews with various direct care professionals, QMRPS, nursing staff, and psychology support staff in homes and day programs throughout campus o Danny Watson, QA Auditor o Charles Bratcher, QA Director o Kim Kargan, QA Auditor <u>Observations Conducted</u>: o Whiterock Unit Morning Meeting 3/24/10 o Daily Incident Management Meeting 3/24/10 o Human Right Committee Meeting 3/23/10 o PSP meetings for Individual #230 and Individual #480 o Shamrock 701, 703, and 705 o Barnett B7 and B8 o Whiterock W2, W3, W7 and W8 o Longhorn L1, L3, L4, L6 o Martin M1, M2, M4, and M6 o PAWS Program o STEP Program o Woodshop o Laundry/Folding Workshop o MISD Classroom
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State Policy #006: At Risk Individuals had been developed by the state to address assessing risks for individuals. MSSLC had a policy in place titled "Health Screening and Risk Assessment" dated 9/23/09. Additionally, the state had developed standardized forms to assess health risks, challenging behaviors,

	injuries, and polypharmacy. Further reference in this section of the report to policy will refer to MSSLC policy: Health Screening and Risk Assessment. As evidenced by Health Status Team Training held in March 2010, the facility was making efforts to revise the system for identifying and monitoring risk factors for individuals at MSSLC. A Health Status Team (HST) was in place and was chaired by the Facility Medical Director. The facility had developed a data base to be used by all HST members to ensure assessment information was updated and readily available to PSTs. All PSPs reviewed contained risk ratings for each individual in each of the categories specified in the Settlement Agreement. As discussed further in this section of the report, risk ratings were often not consistent with current diagnosis and recent incidents for each individual. All individuals served at MSSLC were admitted to the facility because they were considered to be at high risk for health and/or behavioral issues. Risk assessments should be more than a perfunctory review of risk factors for each individual. Comprehensive risk reviews that consider and address factors that contribute to each risk area need to be completed and all staff need to be aware and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. The monitoring team recommends that the facility clarify the purpose of the identification of at-risk individuals.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The facility policy mandated a risk review at least every six months for each individual by a Health Status Team (HST). The policy identified who should participate on the team and assigned specific responsibilities to team members. Determining risk levels was done in a manner that allowed very vulnerable individuals to not be properly identified as being at risk, in part because of the assumption that if a plan, no matter how inadequate, was developed to address the risk, risk no longer existed. Below are examples of risk assignments and risk incidents. First, regarding overall facility data: • During the dates discussed above, 90 individuals were seen in the emergency room and 52 individuals were hospitalized. • Of 142 combined acute care events, 54 involved respiratory events, the majority of which were pneumonia. While nearly 42% of the acute care ER/hospital events involved respiratory issues, only five individuals were ranked “high” on the respiratory risk list. • Seizures/medication toxicity accounted for 15 ER/hospitalizations, but not one of the 38 individuals on the “High Risk List” dated 2/28/10 was listed as high	

#	Provision	Assessment of Status	Compliance
		risk due to seizures. • From March 2009 to March of 2010, 47 individuals were diagnosed with pneumonia, and 11 with a diagnosis of aspiration pneumonia. Physicians were reluctant to label aspiration pneumonia without radiological evidence, but this did not exclude the possibility that other pneumonias were also due to aspiration. • Cellulitis or sepsis accounted for 14 events, yet there was no recognition that this issue was even considered a risk issue to be managed. • GI and Bowel issues, such as GERD, constipation, and impaction accounted for six or seven hospital admissions only. The level of serious bowel issues represented a very low frequency for a facility of this size. Second, regarding specific individuals: • Individual #5 had two hospital admissions, one for pneumonia and the second for respiratory difficulty, but was a 3 (low risk) on the aspiration list, with no other respiratory risk listed. • Individual #16 had two acute care admissions for pneumonia, but was a 3 on the aspiration list. • Individual #34 was admitted twice for pneumonia, once for a collapsed lung and once for GERD, but was a 3 on the aspiration list. • Individual #25 had 12 hospitalizations in the last 12 months, two of which involved GERD, but he was a 3 (low risk on the GERD risk list). He was a 2 (moderate risk) on the GI list. He also had 2 hospitalizations involving status epilepticus/seizures, but was only listed at moderate risk for seizures. • Individual #5 was the only individual identified at high risk for seizures, even though she had no acute issues with seizures, yet she had one admission for pneumonia in 8/09 and another for respiratory difficulty in 9/09. • Individual #95 had two hospital visits and one admission for a GI bleed, but was listed at low risk for GI issues on the GI risk list. GI issues in this population are most often related to GERD, which is often the root cause, yet there were separate lists for individuals with GI issues, GERD, and aspiration. Individual #95 was a 3 (low risk) on all of these items. • A number of individuals had a hospital discharge diagnosis of malnutrition or dehydration, including Individual #25, Individual #509, and Individual #48, but only Individual #25 was identified at high risk.	
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	The policy stated that the Health Status Team (HST), chaired by the Primary Care Provider, would ensure a preventive approach to the health and safety of persons served by assigning each individual a risk level/rating. High Risk (level 1) would apply to an acute or unstable condition that would require increased intensity of intervention to achieve an optimal health outcome. Furthermore, it stated that individuals discharged	

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	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.	from the hospital should have their risk level reviewed by the physician. The policy mandated that once a high risk condition was identified, the PST would meet within five working days to formulate a plan. The plan must be implemented within 14 days and incorporated into the individual's PSP. The PST was required to meet at least every 30 days to monitor the effectiveness of the plan of care until the individual's condition was stabilized and the risk level was reduced. The current policy allowed for a risk level to be deemed medium risk (level 2) if the individual had adequate supports that were actively monitored for any assigned risk category. Review of support plans did not support that adequate preventative measures or plans were in place or that adequate monitoring of implementation was occurring. Thus, the monitoring team could not support the practice of lowering individual's risk level from high to medium just because a plan was in place to address the issue. Until the facility develops an effective plan of monitoring and revising supports as needed, it is recommended that risk levels are assigned cautiously to ensure proactive measures are taken to monitor each individual's health and safety. Some examples and detail are provided below. • Individual #401 was listed as low risk in all areas with the exception of cardiac which was rated as medium risk. She had been diagnosed with osteoporosis and was treated for a hip fracture on 10/29/09. She had a 19-day hospital stay in October 2008 due to pneumonia, and then was admitted to the hospital again in November 2008 for pneumonia. She had diagnosis that included GERD, Hypertension, Constipation, Osteoporosis, and Diabetes. • Individual #331 was rated as low risk for osteoporosis and injury, but his PSP noted that he had osteoporosis and had a long history of bone fractures, including fracture of 1st and 2nd toes, fracture of right 3rd metacarpal, fracture of right lateral malleolus, fracture of left 4th finger, fracture of left ankle, fracture of left fibula (x2), fracture of right patella, fracture of 5th finger, and depressed occipital skull fracture. There was no discussion in his PSP regarding how the fractures were obtained and how further fractures may be prevented. Most individuals at risk for various conditions were not identified, but there were other processes that attempted to fill in the gaps. For example, the nursing department had a "weight loss committee" that tracked individuals based upon certain weight change criteria (e.g. overweight or underweight). This group operated independently from the interdisciplinary process, but had worked to focus on individuals with insidious weight loss independent of the "risk identification process."	

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I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the PST. The PSPs that were reviewed included strategies to address identified risks, but again, not all risks were identified as a risk for each individual. Direct care professionals reported that they were notified of changes in plans by therapist or their supervisor and implementation of changes began immediately. There was a communication system in place to share changes in risk levels and alert staff to monitor individuals at risk, but again, risk was not accurately identified so that this system could be effective at minimizing risk. One example demonstrated the problems that occur without effective assignment of risk and interdisciplinary integrated processes: • Individual #95 was 22 pounds below the bottom of his IBW and was more than 30 pounds below the mid-range of his ideal body weight. Although he was being tracked by the nursing weight loss committee, he was listed a 2 on the weight loss or gain risk list. He received Fosamax, a drug used for increasing bone density, but which can cause esophagitis in individuals who cannot sit at 45 degrees or higher for at least an hour following administration. This drug could be dangerous to persons with immobility and extensive bony deformity. Further, he had an active GERD diagnosis. Nursing expressed recognition of this problem. Individual #95 had one hospitalization for a GI bleed. He was also receiving Depakote Sprinkles, which can have a major side effect of irritating the stomach. He had more than one skin breakdown, but there was no evidence that the team considered that this could be related to his altered nutritional status related to GERD.	

Recommendations:

1. Develop a system to accurately identify any individuals whose health or safety is at risk. Risk levels should be evaluated considering the level of support needed in each risk area.

2. Establish written policies regarding the types of incidents that would require immediate review of the individual's risk assessment including unusual incidents, hospitalizations, and ER visits.

3. All staff should receive individual specific training on each safety and health care risk identified for the individual(s) they are assigned to support.

4. All health issues should be addressed in PSPs and direct care professionals should be aware of health issues that pose a risk to individuals and

know how to monitor those health issues and when to seek medical support.

5. Clinicians need cross-disciplinary training regarding the well-documented relationship between GERD, chronic esophagitis, and skin breakdown.

6. There was insufficient recognition at MSSLC of the seriousness of insidious weight loss, which is usually a symptom of a serious condition, rather than a condition itself. There should be joint collaboration between medicine, nursing, and the nutritional management process.

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:	At the time this report was issued, information on the facility's provision of psychiatric care and services was not available.

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 Employee Continuing Education or Miscellaneous Training Roster (sheets for each psychologist documenting staff trained, undated) o Psychology Caseload BSP Monitoring (tool used for training PBSPs, undated) o Schedule of individual and group therapies for Longhorn, Shamrock, and Whiterock o IPE Log Psychology Department (undated) o Psychology Department Tracking of Psychological Assessments (undated) o Psychological Services (from Home Life Training Manual, 1/22/09) o Psychology Department Staff Roster (dated 3/3/10) o DADS Policy #008, Structural and Functional Assessment Report (dated 11/30/09) o DADS Policy #008, Psychological and Behavioral Services, (dated 11/13/09) o Personal Support Plans (PSP) for: • Individual #3 (from document request), Individual #27, Individual #330, Individual #422, Individual #269, Individual #261, Individual #481, Individual #432, Individual #475, Individual #110, Individual #256, Individual #171, Individual #493, Individual #327, Individual #236, Individual #183, Individual #301, Individual #6, Individual #589, Individual #385, Individual #112, Individual #68, Individual #408, Individual #488, Individual #356, Individual #300, Individual #179, Individual #304 (from document request) o Functional Assessments for: • Individual #191, Individual #269, Individual #261, Individual #481, Individual #432, Individual #422, Individual #110, Individual #256, Individual #171, Individual #493, Individual #327, Individual #236, Individual #183, Individual #301, Individual #6, Individual #589, Individual #385, Individual #112, Individual #68, Individual #356, Individual #300, Individual #179, Individual #304 o Positive Behavior Support Plans (PBSP) for: • Individual #462 (reviewed in Psych clinic), Individual #3 (from document request), Individual #488 (PBSP presented in BTC), Individual #559 (PBSP presented in BTC) , Individual #330 (PBSP presented in BTC), Individual #164 (PBSP presented in BTC), Individual #317 (PBSP presented in BTC), Individual #261, Individual #422, Individual #191, Individual #27, Individual #269, Individual #481, Individual #432, Individual #475, Individual #110, Individual #256, Individual #171, Individual #493, Individual #327, Individual #236, Individual #301, Individual #314, Individual #183 , Individual #6, Individual #589, Individual #385, Individual #112, Individual #68, Individual #408, Individual #356, Individual #300, Individual #179, Individual #304 (from document request), Individual #513 (from record found in Martin) o Psychological Evaluations for:

- Individual #27, Individual #191, Individual #330, Individual #327, Individual #236, Individual #301, Individual #408, Individual #300, Individual #179, Individual #304 (from document request), Individual #68, Individual #141, Individual #561, Individual #57, Individual #483, Individual #566, Individual #129, Individual #445, Individual $576, Individual #416, Individual #79, Individual #303, Individual #205, Individual #262, Individual #500, Individual #232, Individual #507, Individual #403, Individual #496, Individual #211, Individual #527, Individual #547

Interviews and Meetings Held:

- Charlotte Kimmell, Ph.D., Director of Psychology
- Chris Christensen, MA, psychologist for Martin
- Michael Grimmett, Ph.D., psychologist for Shamrock
- Mark Richards, MA, Assistant Director of Psychology
- Psychology Department Meeting
- Behavior Therapy Committee (BTC) Meeting
    - Staff attending: Charlotte Kimmell, Ph.D., Director of Psychology; Mark Richards, MA., Assistant Director of Psychology; Andrew Griffin, Ph.D., Psychologist; Michael Grimmett, Ph.D., Psychologist; Daniel Davidson, MA., Psychologist; Craig Biggars, MA., Psychologist; Valerie McGuire, Director QMRP; Alan La Grone, MD, Psychiatrist
    - Individuals presented: Individual #488, Individual #164, Individual #317, Individual #330, Individual #354, Individual #191, Individual #559, Individual #154
- Psychiatric Clinic
    - Staff attending: Dr Kendrick, MD, Psychiatrist; Mitzi Daniel, RN; Michael Grimmett, Ph.D., Psychologist; Dalia Rhone, Psychology Assistant.
    - Individuals presented: Individual #462, Individual #586, Individual #394, Individual #379, and Individual #332.

Observations Conducted:

- Staff Training for a PBSP
    - Staff conducting the training: Andrew Griffin, Ph.D., Psychologist; Lupita Alfano, psychology assistant; Valerie Jackson, MA, pre-doctoral intern.
- 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 including, for example:
    - Assisting with daily care routines (e.g., ambulation, eating, dressing),
    - Participating in educational, recreational and leisure activities,
    - Providing training (e.g., skill acquisition programs, vocational training, etc.), and
    - Implementation of behavior support plans

Facility Self-Assessment:

A facility self-assessment was not provided because this was a baseline review.

	Summary of Monitor's Assessment: Several areas associated with this provision of the settlement agreement required improvement. These areas included data collection and data presentation, and the overall quality and comprehensiveness of the functional assessments and Positive Behavior Support Plans (PBSPs). Additionally the facility lacked the use of several critical behavioral systems, such as inter-observer agreement of target and replacement behaviors, treatment integrity measures, peer review, and a system to ensure that all staff have been trained in the use of each individual's PBSP. The monitoring team believes that these needed improvements resulted primarily from a lack of training and inexperience in ABA (applied behavior analysis) methodology, rather than from a lack of effort or commitment on the part of the psychologists at MSSLC. Therefore, the monitoring team believes that the psychology staff responsible for writing and monitoring PBSPs should receive formal training and supervision in ABA. Court-mandated psychological assessments of individuals at MSSCLC were time-limited (by the courts) and appeared to be comprehensive. Psychological assessments for the other individuals at the facility, however, required attention. Many individuals did not have assessments, and many more had assessments that were over 20 years old. The facility should develop a plan to ensure that all individuals residing at MSSLC have a current, accurate, and complete psychological assessment.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	At the time of the on-site tour, no Psychologist at MSSLC was a Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA). One of the psychologists was enrolled in a BCBA program. The psychologist who worked in Shamrock believed that he had the coursework and experience to qualify to sit for the BCBA exam, and indicated that he was planning to apply to the board soon. The attainment of a BCBA is important because it represents an objective measure of competence in applied behavior analysis. Additionally, the course sequence necessary to sit for the national exam presents practical and important information on topics, such as data collection, graphic presentation and interpretation of data, functional assessment, and behavioral interventions that the monitoring team believes would be beneficial in enhancing the behavioral skills of the current psychology staff. At the time of the on-site tour, no plan or policy for obtaining BCBAs for psychologists who write Positive Behavior Support Plans (PBSPs) was in place. All of the psychologists who were responsible for writing and monitoring PBSPs had attained advanced degrees in psychology. Four of the department's 19 psychologists had Ph.D.s, while the remaining 15 psychologists had masters degrees. It was clear from reviewing the PBSPs that the facility was working very hard to identify, and minimize, those conditions and setting events related to individual's dangerous and destructive	

#	Provision	Assessment of Status	Compliance
		target behaviors. Nevertheless the monitoring team believed that, in general, the PBSPs were not as effective as necessary to adequately address the behavioral needs of many of the individuals residing at MSSLC (see K9 below for a more detailed review of PBSPs).	
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.	MSSLC employed a Director of Psychology. She possessed a Ph.D., and was a licensed psychologist. The director had over 30 years of experience working with individuals with developmental/intellectual disabilities. Additionally she was a Certified Sex Offender Treatment Therapist, and a Certified School Psychologist. The director's curriculum vitae indicated that she had remained current in the field of psychology with recent presentations and workshops at professional conferences, and active involvement in state psychological associations. The monitoring team believes that she possessed the professional credentials and qualifications to be an effective director of psychology at MSSLC.	
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.	DADS established a policy (Psychological and Behavioral Services, policy #008) that required a peer-based system of review of PBSPs. The monitoring team could find no evidence that peer review was occurring at MSSLC. An active peer review system would allow the psychology staff to share their strengths and insights with each other and would result in improved overall quality of PBSPs. Peer review at the facility should occur weekly and, at minimum, consist of PBSP authors, direct care professionals (DCPs) who implement the plans, and those that supervise the implementation of behavior plans. The psychology department conducted weekly Behavior Therapy Committee (BTC) meetings that were designed to review and approve new and annual PBSPs. During the on-site tour the monitoring team observed a BTC meeting that contained many of the elements of a peer review meeting (as defined above and in the Psychological Services section IV of the Home Life and Training Manual). It is possible that the BTC meetings could be expanded to include the opportunity to present challenging cases for peer discussion and feedback, beyond those which come up for scheduled initial approval or annual review. Additionally, the monitoring team recommends that peer review be extended by adding monthly external peer review meetings consisting of, at minimum, other Texas DADS BCBAs and supervisors (perhaps by teleconference). Operating procedures for these peer review committees will need to be established.	

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K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	A standard methodology for PBSP data collection was not apparent at MSSLC. The majority of residences and vocational sites used a combination of IACT (Interdisciplinary Approach to Client Training) charts and written record summaries of behavioral events. A psychology assistant in Longhorn (whose job was primarily to collect and analyze data), however, indicated that staff could collect data using either the chart entries or the IACT system. Finally the psychologist at Shamrock indicated that, for some individuals, he used a version of a scatter plot to record target behaviors across specified times of the day and evening. Although a data system needs to be flexible and responsive to individual needs, a standard basic methodology should be established across the entire facility. The IACT charts were essentially a structured ABC data collection system in which antecedent and consequent events were recorded for every target behavior (including replacement behaviors) that occurred. The generally accepted professional standard of care is that this type of data collection system is typically used during assessment (and data collection is usually conducted by psychologists rather than DCPs), but not during treatment implementation. The reason for this is that the use of ABC systems makes it very difficult to collect reliable data because staff need to choose the appropriate antecedent event and the specific consequence that occurred each time one of the target behaviors occur. Further, ABC systems often lead to a bias towards concluding that attention was the maintaining variable (also see below in section K5). Additionally ABC data can be very difficult to accurately interpret. As a result, for example, the psychologist in Shamrock substituted a scatter-plot method of data collection for the IACT method for Individual #422. The psychologist's goal was to get a clearer and more accurate measure of the relationship between periods of physical pain and physical aggression and self-injurious behavior. The better understanding of why Individual #422 engaged in target behaviors that this simplified data collection system provided, could potentially translate to a more effective PBSP and better outcomes. Finally, the written record entries generally occurred at the end of the shift, and all staff interviewed reported that it was difficult to accurately recall what occurred in detail earlier in the shift. Data reliability (or inter-observer agreement) was not formally assessed at MSSLC. Moreover, all psychologists interviewed indicated that they did not have confidence in the PBSP data collected by the DCPs. The only exception was at Shamrock, where data reliability was assessed for four selected individuals. Interestingly, the psychologist at Shamrock was also the only psychologist who indicated that he believed that data collection was reliable in at least a few of the Shamrock homes. The monitoring team recommends that a standard methodology for PBSP data collection be developed, and	

#	Provision	Assessment of Status	Compliance
		that it be simplified (such as that used with some individuals at Shamrock), and reliability data be collected for all individual's PBSP data. All PBSP target and replacement behaviors were graphed monthly. That is, each datum point represented one month of data. Some target and replacement behaviors, however, need to be graphed more frequently to ensure that sufficient data-based decision-making can occur. Monthly data points, for example, would not allow one to identify the effects of a new medication or change in the PBSP for several months. A more sensitive data system (i.e., each datum point representing weekly data or even daily data) that identifies behavioral trends quickly could assist the psychiatrist or psychologist in the most effective use of a medication or treatment intervention. It is important that graphed data of target and replacement behaviors are reviewed at least monthly, or more if needed, by each psychologist and monthly summaries are documented. In reviewing 35 PBSPs, only three monthly notes summarizing target and replacement behavior data were found (Individual #3, Individual #261, and Individual #422). Additionally although several PBSPs data indicated no change, or even an increase in undesirable target behavior, there were no examples found of PBSPs that were modified to address the absence of behavioral improvement (although some were modified as a function of the annual PBSP review process). It is important when individuals' data trends in an undesirable direction that hypotheses be developed (perhaps requiring the redoing of the functional assessment) and modifications to the PBSP occur immediately (rather than waiting until the annual PBSP review).	
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.	<u>Psychological Assessments</u> The psychological assessments conducted at MSSLC implemented standard psychological assessment procedures that provided for the identification of medical, psychiatric, and environmental issues that affected each individual's behavior. At the time of the on-site tour, the majority of new admissions to the facility were court ordered under the state's Family Code Sec. 55.33 for juveniles or Code of Criminal Procedure 46B.073 for adults with the requirements for assessment of (a) mental retardation and (b) legal competency. Results of these assessments were used to determine the next step for these individuals, that is, whether they were transferred to another facility within the Texas legal system or were admitted to MSSLC. These assessments generally consisted of the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR), structured interviews which included a review of personal history, standardized intelligence testing (e.g., Stanford-Binet Intelligence Test, Wechsler Intelligence Scale for Children, Wechsler Adult Intelligence Scale), standardized assessment of adaptive skills (e.g., Street Survival Skills Questionnaire, Academic skills testing, Vineland Adaptive Behavior Scales), and use of a	

#	Provision	Assessment of Status	Compliance
		Psychiatric rating scale (e.g., the Reiss Screen). Additionally, all individuals receiving court ordered assessments were evaluated by a psychiatrist. Functional Assessments An effective functional assessment should help the behavior analyst to better understand the target behavior, so that he or she could ultimately change each individual's behavior. Of the 357 individuals with PBSPs at MSSLC, 53 had completed functional assessments at the time of the on-site tour. Functional assessments should be completed for all individuals with a PBSP or those whose records indicate a behavioral need. The functional assessment tool used at MSSLC (DADS Structural and Functional Assessment Report) included all the procedures commonly accepted by the field of applied behavior analysis to be important to consider when attempting to understand the variable or variables maintaining a behavior. These include differentiation between learned and biologically based behaviors, identification of antecedents and consequences relevant to the undesired behavior, the identification of the individual's preferences, and the identification of functionally equivalent replacement behaviors relevant to the undesired behavior. Additionally, the structural and functional assessment report format developed by DADS included all the relevant steps of conducting an effective functional assessment including both indirect and direct measures. One of the 23 functional assessments reviewed by the monitoring team did not use the DADS functional assessment format (Individual #191). The majority of the functional assessment reports, however, did not contain at least some components of the DADS format. For example, none the assessments reviewed identified replacement behaviors and general teaching strategies outlined in the DADS format. All functional assessments should use the same report format and incorporate all components included in the DADS structural and functional assessment report. The monitoring team found the thoroughness and usefulness of the functional assessments (for developing an effective PBSP) to not meet the generally accepted professional standard of care as defined in section K of the Settlement Agreement. Even so, there were some examples of functional assessments that contained useful information. For example functional assessments for Individuals #256, #68, #110, and #269, were more thorough. They attempted to differentiate between learned and biologically based behaviors, included both indirect and direct assessment measures, identified relevant antecedent and consequences related to the target behavior, and attempted to identify individual preferences and reinforcers. These four functional assessments represented a good starting point for all functional assessments at MSSLC. Over subsequent on-site tours, however, the monitoring team will be looking for a more in depth analysis to be conducted in the functional assessments. For example, the monitoring team will be looking for • indirect assessment techniques,	

#	Provision	Assessment of Status	Compliance
		• direct assessment techniques that included the collection and analysis of descriptive data (e.g., ABC data) at minimum (the above functional assessments included only direct observations without data collections), • the inclusion of a functional analysis, when necessary , and • the use of systematic preference assessments when preference surveys do not identify effective reinforcers. The majority of functional assessments reviewed (22 out of 23) identified at least one antecedent or setting event and consequence likely to be related to one or more target behaviors. For example Individual #300's functional assessment concluded that "an increased level of supervision, familiar staff, and being on a smaller more structured locked behavioral unit all served to minimize Individual #300's problem behaviors." This functional assessment, however, was not complete because it did not include any direct measures of the target behavior. Individual #300's functional assessment, and the majority of functional assessments reviewed (17 of 23), included a review of the PBSP data and/or a review of observation notes, but no clear direct observations or data collected. As discussed above, direct observation and documentation of target behaviors are the beginning of a thorough functional assessment. Actual data collection and graphic presentation of direct observations in combination with meaningful indirect measures (e.g., interviews) that lead to a better understanding of the target behavior, is the ultimate purpose of a functional assessment. Many of the functional assessments reviewed had identified variables that were poorly defined and were not useful for understanding the target behavior (although some were better than others). For example, Individual #327's functional assessment concluded that Individual #327 engaged in physical aggression when he got mad. Similarly, Individual #301's functional assessment suggested "being angry" as an antecedent for aggressive behavior. These types of explanations do not help to understand why the target behavior occurred or what was maintaining it. A more thorough functional assessment would attempt to understand why these individuals got angry and engaged in physical aggression. That is, the behavior analyst wants to know what is occurring (or not occurring) in the environment that may increase the likelihood that aggression will occur in the future. This includes determining what consequences of the aggression and anger may be maintaining those behaviors. Twenty-two of the 23 functional assessments reviewed used behavior rating scales to help identify the variable or variables maintaining the target behaviors. Most functional assessments used both the Motivation Assessment Scale (MAS) and the Functional Analysis Screening Tool (FAST) across one or more raters. Both scales are often used by behavior analysts and can be useful as a structured format for obtaining DCPs' opinions on the possible variable or variables maintaining an individual's target behaviors. They	

#	Provision	Assessment of Status	Compliance
		can be very useful when they yield clear differentiation among potential sources of motivation for target behaviors. On the other hand, they are often unhelpful when raters, tools, and results vary (research has shown that these tools are often not reliable in their results). Thus, it was not surprising to find that the majority of functional assessments revealed ambiguous results from these tools. This outcome led to functional assessment conclusions that were often very general (e.g., the target behavior occurs when the individual wants something, wants to get out of something, or is bored). The result was that these functional assessments did not help the reader to identify the source of motivation for the target behavior; therefore they were of little value in guiding the development of the PBSP. The following example was typical: • Individual #481's functional assessment indicated that the MAS suggested her self-injurious behavior (SIB) was maintained by the sensory stimulation it created and also by access to tangible reinforcers. Results from the FAST, however, concluded that problem behaviors were most likely to occur when Individual #481 was not receiving attention, or when the DCPs were paying attention to someone else. Although this functional assessment clearly involved considerable time and effort from the psychologist who conducted, analyzed, and wrote up the results, the conclusions were ambiguous, and do not lend themselves to clear antecedent and consequence recommendations for the PBSP. Ideally the indirect component of a functional assessment (interviews of DCPs, behavior rating scales, etc.) would reveal some common themes that then can lead to working hypotheses concerning the variable or variables potentially affecting an individual's target behaviors. These hypotheses can then be further refined (or abandoned) based on the results of direct components of the functional assessment (direct data collection). If the behavior analyst is confident that indirect and direct measures have suggested clear sources of control of the targeted behavior, then the functional assessment is complete, and the results of the assessment can be used to develop the PBSP. If the results of the functional assessment are still not clear, or the PBSP is not producing the desired results, the behavior analyst will then attempt to use other assessment tools such as a functional analysis to better understand the variables affecting the target behavior. In addressing complex behavior problems, functional assessments are often revised and redone several times. There was no evidence that the functional assessments at MSSLC were revised when the individual's behavior failed to meet treatment expectations.	

#	Provision	Assessment of Status	Compliance
		MSSLC should consider regular incorporation of functional analysis procedures. There is a large literature on the ways to conduct functional analyses. This will, however, require the oversight of a competent and experienced behavior analyst. It will also require the development of standard policies and protocols regarding functional analysis procedures.	
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.	Twenty-six of the 32 psychological assessments reviewed represented court ordered assessments of individuals with suspected mental retardation and were in the legal system. The purpose of these evaluations was to identify appropriate diagnoses and to recommend an appropriate placement to the court. All of these psychological assessments reviewed appeared to be based on current, accurate, and complete clinical and behavioral data. The content and results of the psychological assessments for the other six individuals were not based on current, accurate, and complete clinical and behavioral data (also see section K7 below).	
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.	A spread sheet developed by the psychology department to track psychological assessments for all individuals at MSSLC indicated that approximately 200 individuals did not have psychological assessments. More than half of the psychological assessments completed were more than 20 years old, with the oldest assessment completed in 1978 (Individual #260). The settlement agreement requires that a psychological assessment be completed for each individual residing at the facility. The guidelines for re-testing and assessment found in the psychological services section of the Mexia Home Life and Training Manual (exhibit A), stated that "psychological assessments will be completed when it has been determined that there is a clinical need for such an evaluation." This policy, however, does not identify a maximum time between psychological assessments for any individual. Individuals who are juveniles committed under the state's Family Code required a re-testing every three years. MSSLC should conduct psychological assessments as needed, and at least every five years, for each individual residing at the facility. Additionally, the monitoring team recommends that each individual at the facility receive an annual psychological assessment update. The purpose of the annual update would be to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update would 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. The settlement agreement requires that psychological assessments are conducted within	

#	Provision	Assessment of Status	Compliance
		30 days of admission. The psychology department Initial Psychiatric Evaluation (IPE) log showed that, of the last 16 admissions (beginning September of 2009 and all court ordered admissions), 13 had psychological assessments conducted within 30 days of admission. The remaining three individuals had psychological assessments competed with 45 days. All court ordered commitments to MSSLC required that a comprehensive psychological assessment was started within 30 days of admission and completed within 60 days.	
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 psychology department at MSSLC offered a variety of services in addition to behavior support programs. These included: o Individual counseling o Specialized Treatment and Rehabilitation Services group (STARS) o Social Skills Training group o Physical Sexual Abuse Survivor Program group (PSAS) o Substance Abuse Treatment Program group (SATP) o Anger Management Program group o Specialized Treatment of Paraphilias group (STOP) Daily lists of scheduled groups and individuals participating indicated that a substantial number of individuals from Whiterock, Shamrock, and Longhorn were involved in these groups. The Settlement Agreement requires that needed psychological services (other than behavioral) identified in the psychological assessment are implemented within six weeks of the assessment. Court committed adults are evaluated for 120 days, and juveniles are evaluated for 90 days, prior to the court mandating a placement. These evaluations are applicable to adults for whom the court has ordered an examination to determine competency to stand trial, per the state's Code of Criminal Procedure 46B.073 for adults, and for juveniles for whom court has ordered a report on fitness to proceed with a juvenile court proceeding, per the state's Family Code 55.33. Since the vast majority of admissions to Mexia were court mandated, recommendations for psychological services were not typically made until the court determined that the individual was to be admitted to MSSLC. At that point, these types of psychological services were recommended and initiated. Although it may make sense to delay implementation of some therapies (e.g., regarding sexual-related problem behaviors) until the individual was admitted for long-term placement, participation in other types of therapy may be beneficial and should be considered for all individuals, even for those who were within the evaluation period. For all of these therapy-type services, it is important that they are goal directed with measurable objectives and treatment expectations. An observation of an anger	

#	Provision	Assessment of Status	Compliance
		management group by the monitoring team indicated that this may not be the case. Eight boys participated and the topic was anger and stealing. There was loose discussion, led by psychology department staff, regarding stealing of things from stores. Each boy gave a personal story (it appeared unlikely that all of the stories were true). The topic appeared to have been initiated based upon one boy stealing from another on one of the homes. There did not appear to be a curriculum related to anger management, an assessment regarding what each boy's needs and desired outcome, or any way of measuring outcome. The staff facilitating the discussion appeared caring, were responsive to the boys, and managed to engage every boy during at least a part of the session. Nevertheless, more work is needed to be done to clarify the desired outcomes of this type of therapy. Subsequent monitoring team on-site tours will closely review these services to ensure that they are identified as a need in each individual's psychological assessment, that the services reflect evidence-based practices, and that the services include documentation and review of progress.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	Thirty-five of the 357 written PBSPs at MSSLC were reviewed to assess compliance with this provision. All of the PBSPs reviewed had the necessary consents and approvals. The format used for the PBSPs was consistent with those generally accepted by the field of applied behavior analysis. For example, the majority of PBSPs contained a consideration of medical and psychiatric issues, operational definitions of target and replacement behaviors, a description of potential functions of the maladaptive behavior, treatment expectations and timelines, and behavioral history and outcomes. The majority of PBSPs would benefit from the addition of a short, clear statement summarizing the functional assessment results and providing a rationale for the selection of the proposed intervention (Individual #261's PBSP contained a good example), and a clear description of data collection procedures for target and replacement behaviors (Individual #422 contained a good example). Finally, the plans generally included antecedent and consequent strategies for changing behavior. The quality and potential utility of these plans to actually change behavior, however, varied greatly. The monitoring team uses a tool that lists all of the components that one would expect to find in a PBSP that met the generally accepted professional standard of care as defined in section K of the Settlement Agreement. These include: • Rationale for selection of the proposed intervention. o Evidence that the intervention is based on functional assessment results, individual preferences, and on-going individual behavior.	

#	Provision	Assessment of Status	Compliance
		• History of prior intervention strategies and outcomes. • Consideration of medical, psychiatric and healthcare issues. • Operational definitions of target behaviors. • Operational definitions of replacement behaviors. • Description of potential function(s) of behavior. • Use of positive reinforcement sufficient for strengthening desired behavior. • Strategies addressing setting event and motivating operation issues. • Strategies addressing antecedent issues. • Strategies that include the teaching of desired replacement behaviors. • Strategies to weaken undesired behavior. • Description of data collection procedures. • Baseline or comparison data. • Treatment expectations and timeframes written in objective, observable, and measureable terms. • Clear, simple, precise interventions for responding to the behavior when it occurs. • Plan, or considerations, to reduce intensity of intervention, if applicable. • Signature of individual responsible for developing the PBSP. None of the plans contained all of these required components, and in many cases, the quality of the components that were included ranged along a continuum from adequate to inadequate . Rather than focusing on the number of plans that did or did not contain each of the items listed above, below are noted the types of considerations to which MSSLC needs to attend in order to improve PBSP quality. Specific data regarding sampled PBSPs will be more relevant at that point and will be presented in future monitoring team reports. One of the most important aspects of an effective PBSP is that the interventions clearly follow from the results of the functional assessment. In applied behavior analysis, treatment interventions are based on the variable or variables hypothesized to maintain and occasion the target behavior. Applied behavior analysis treatments should not be based on diagnosis or on the topography of the target behavior. Since only 53 functional assessments were reported to be completed for 357 PBSPs, and because few had functional assessments it was impossible to completely evaluate the PBSPs because hypothesized antecedents and functions had not been identified. Therefore, the following comments focus on only those PBSPs that contained functional assessments. Seventeen of the 35 PBSPs that were reviewed contained a functional assessment (or referred to a separate document that described the functional assessment) Of these 17, only three contained adequate evidence that <u>both</u> the antecedent and consequence interventions were based on the functional assessment results. For example, the	

#	Provision	Assessment of Status	Compliance
		functional assessment for Individual #110 indicated that he engaged in SIB to obtain tangible items (the psychologist hypothesized that DCPs intermittently provided edible reinforcers in an attempt to decrease his target behaviors), as well as by attention from staff. The antecedent component of the PBSP specified that Individual #110 would be offered second portions of meals, and the consequence component stated that food would never be presented within two minutes of the occurrence of SIB. The PBSP further specified that he would receive food contingent on the absence of SIB and following task completion. Seven of the 17 PBSPs contained antecedent interventions that were based on the results of the functional assessment, but consequences that appeared generic and unrelated to the functional assessment results. Moreover, many consequent procedures presented in the PBSPs would, if the hypothesized function was correct, increase the undesired target behavior. Some comments are presented below: • Individual #432's functional assessment indicated her target behavior (screaming) was maintained by access to tangible items and staff attention. The antecedent intervention, adding opportunities for Individual #432 to receive coffee and staff attention for requesting it appropriately was clearly related to the hypothesized function of the target behavior. The consequence, however, specified that screaming was to result in staff prompting her to make her requests appropriately, model appropriate ways to make her request, and direct her to a preferred activity such as drinking coffee. • This pattern of hypothesizing regarding a function of the target behavior, establishing procedures to prevent the behavior, and then specifying procedures to strengthen the target by providing the hypothesized reinforcer contingent on the target behavior, was commonly observed in the PBSPs reviewed. • Another common theme of the PBSPs reviewed was many interventions looked extremely similar and appeared to describe general therapeutic procedures, rather than individualized interventions based on the results of a functional assessment. For example the interventions for Individuals #236, #301, and #327 looked almost identical, including recommendations to try to help them solve their problems, warn them of transitions, warn them to stop, tell them what was expected, discuss the incident with them after they are calm, and so forth. The identification of replacement behaviors was present in the majority of PBSPs reviewed, however, specific strategies for teaching these behaviors was generally not present. Specific skill acquisition plans should be reliably implemented for replacement behaviors. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the	

#	Provision	Assessment of Status	Compliance
		facility. These plans should be based upon a task analysis (when appropriate), have behavioral objectives, contain a detailed description of teaching conditions, and include specific instructions for how to conduct the training and collect data (see section S1 below for a more complete review and discussion on the use of skill acquisition plans at the facility). Another common characteristic of the 35 PBSPs reviewed, was the absence of obvious potent consequences of behavior. A few PBSPs included providing praise and, in some cases, tangible items for the absence of target behaviors. In many of those PBSPs, however, neither staff attention nor access to the tangible item was reported to be maintaining the target behavior or a reinforcer for the individual. When the monitoring team asked staff why there were not more potent reinforcers made contingent on the absence or reduction of target behaviors, they were told that staff believed they could not use the most potent available reinforcers such as access to special events or individual preferred activities. The monitoring team was quite surprised, if not shocked, to find that the use of positive reinforcement to support appropriate behavior was not evident anywhere on the MSSLC campus. The use of positive reinforcement is a generally accepted professional standard of care in the treatment of individuals with developmental disabilities, including those with co-occurring psychiatric disorders. The monitoring team found no evidence of differential reinforcement systems, token or point systems, or contingent reinforcement. Changing and improving individual behavior across every unit at MSSLC will be difficult, if not impossible, without the planned, thoughtful use of positive reinforcement. The use of positive reinforcement, such as the earning of special privileges or items (and thereby the potential failure of an individual to earn these privileges or items), should not be viewed as competing with the facility's (and the state's) goal of having positive behavior support plans. This was discussed at length during the on-site tour, and the monitoring team hopes that the facility will embrace the many well-researched applications of positive reinforcement contingencies. The psychologists who develop and manage the PBSPs should have the opportunity to program the most potent reinforcers available to encourage desirable and discourage dangerous and undesirable behavior in the individuals they serve. Access to more potent reinforcers is not a substitute for incomplete functional assessments or PBSPs, however, the inclusion of the most potent reinforcers for desired behaviors is not only a best practice in ABA, it would likely enhance the effectiveness of a well written, function-based plan.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding	Inter-observer agreement was periodically collected for the target behaviors of four individuals residing in Shamrock. A system to regularly assess the accuracy of all individual's PBSPs and replacement data is a best practice in applied behavior analysis, and a necessary requirement for determining the efficacy of treatment interventions.	

#	Provision	Assessment of Status	Compliance
	the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	PBSP data were consistently graphed monthly at MSSLC. As discussed in K4, however, these data should be graphed and presented in increments that would be sensitive to individual needs and situations (e.g., daily or weekly graphed data to assess the changes associated with a change in medication or target behaviors). These graphs should include horizontal and vertical axes and labels, condition change lines and label, data points, a data path, and clear demarcation of changes in medication, health status, or other relevant events.	
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 direct care professionals (DCPs) interviewed indicated that they understood each individual's PBSP. When asked to explain how they would respond to specific target behaviors, they typically responded with general interventions that were consistent with the written plans. Nevertheless, because the consequence procedures in many PBSPs were often generic (see discussion in K9), it was difficult for the monitoring team to determine the accuracy of the DCP's description. One example of a PBSP being implemented with integrity was found during a tour of the Martin residence. The monitoring team encountered Individual #513 who was wrapped in a blanket. In questioning the staff as to why he was wrapped, the monitoring team was informed that he requested the wrap. His program specifically described the wrap procedure (so as not to prevent free movement of his arms if he chose to pull them out of the wrap) and the PBSP interventions for decreasing his SIB. The procedures and data collection system presented in Individual #513's PBSP were clearly written and were consistent with those described by the DCP who was with him. The only way to ensure that DCPs can, and do, consistently implement PBSPs as written, is to establish and implement a systematic treatment integrity assessment tool. This tool would allow psychologists writing the plans to assess if each DCP is implementing the PBSP as written. It would also provide the psychologist with a methodology to train, and re-train as needed, each DCP who will interact with that individual. There was no evidence that MSSLC implemented a system to monitor and ensure treatment integrity.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the	MSSLC did not maintain training logs that reflected if DCPs had received training on individual PBSPs. Each psychologist, however, maintained inservice sheets documenting the training of each staff on each individual's PBSP. The monitoring team observed a training of two DCPs for a new PBSP developed for Individual #20. The psychologist from Whiterock and a doctoral psychology intern conducted the training. The training consisted of a didactic presentation of the PBSP and data collection immediately prior to the implementation of the PBSP. More than these two staff, however, were scheduled to	

#	Provision	Assessment of Status	Compliance
	overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	work in Individual #20's residence. When asked how those other staff would be trained, one of the DCPs, a supervisor on the shift, indicated that he would give the staff time to read Individual #20's PBSP prior to working with him. The DCPs had opportunities to ask questions throughout the training. Competency was assessed by asking the following questions: • Name the target behaviors • How would you intervene? • Name the replacement behavior • Name the prevention strategies • Name the outcome goal on the BSP • Does the client (MSSLC's terminology)have restrictive procedures in their BSP? • Does the client have restraint in their BSP? • Are restraints allowed for this client? Following the staff's responses the trainer indicated if more training was needed, and the areas in which subsequent training took place. This does not represent sufficient competency-based training. In addition to the above training, the facility should observe each staff member implement the plan and provide additional training and feedback until each staff member demonstrates that he or she can implement the PBSP with integrity. It was not clear how follow-up on staff training occurred and how needed training was tracked. It also was not clear from the inservice sheets if staff training was conducted throughout the duration of the PBSP. The facility had a policy not to float staff from one residence to another. Several DCPs, however, reported that staff were often floated from one unit of a residence to another unit of the same residence. It was not clear how the facility ensured that those floated staff had been trained in the implementation of each individual's PBSP. It is recommended that the facility develop a more coordinated system to ensure that all staff (floated staff) are trained in the implementation of each individual's PBSP. It is also recommended that the facility establish an integrity assessment to determine the extent that staff implement the PBSPs as intended.	
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.	The psychology department employed 19 psychologists and 10 psychology assistants serving 450 individuals. While the total number of psychology staff was appropriate for the population served at MSSLC, improvement must be made in the number of psychologists who have training and expertise in applied behavior analysis (i.e., attained certification as a behavior analyst).	

Recommendations:

1. Develop a policy and plan to ensure that all psychologists writing and monitoring PBSPs at MSSLC are competent in applied behavior analysis, and obtain board certification for behavior analysis (BCBA).

2. Establish internal and external peer review systems for PBSPs.

3. Establish a standard, simplified methodology for the collection of PBSP and replacement behavior data that lends itself to reliable data collection. Develop a method and plan to assess data reliability.

4. PBSP target and replacement behaviors should be graphed at a frequency sufficient to promote effective decision-making.

5. Ensure that target and replacement behavior data are reviewed and documented at least monthly.

6. Ensure that modifications to PBSPs reflect data-based decisions.

7. Functional assessments need to be completed for all individuals with a PBSP.
    a. All functional assessments should use the same report format.
    b. All functional assessments should include both direct and indirect measures.
    c. Functional assessments need to be revised when an individual's behavior change does not meet treatment expectations.

8. Psychological assessments should be completed for every individual residing at MSSLC.

9. Psychological re-assessments should be conducted as often as needed, but at least every five years.

10. Ensure that all individuals receive annual psychological assessment updates.

11. All psychological services provided should be goal directed with measurable objectives and treatment expectations.

12. Ensure that PBSPs are based on functional assessment results.

13. Ensure that specific training strategies and procedures are present for the development of replacement behaviors identified in the PBSP.

14. PBSPs should include potent consequences for the absence of target behaviors, including contingent positive reinforcement.

15. The facility should implement a treatment integrity system to ensure that PBSPs are understood and implemented as intended.

16. Develop a system to ensure that all staff are trained prior to implementation, and throughout the duration, of each individual's PBSP.

SECTION L: Medical Care	
	At the time this report was issued, information on the facility's provision of medical care was not available.

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> ○ Reviewed the requirements of the separate monitoring plan, identified as Health Care Guidelines ○ Alternative Facility Status Review dated 03/25/2010 ○ Health Issue Descriptions used for determining risk ratings for: • Choking, Dehydration, GI Concerns, Injury (Causing harm to Self or Others, Impaction/Bowel Obstruction/Constipation, Osteopenia/Osteoporosis, Pneumonia and Swallowing, Chronic Respiratory Infections, Skin Integrity, Seizures, Weight Loss or gain ○ Risk Level- High, Medium, Low ○ Pica List ○ Continuous Movement List ○ Outlier List regarding weights from nursing ○ Data summaries for infection control quality enhancement ○ Code Blue Emergency Drills ○ Dental Services Department Infection Control Policy ○ Emergency Training Curriculum ○ Emergency Room and Hospitalization Lists ○ Policies and Procedures regarding Medication Administration ○ Medication Administration Schedule ○ Medication Error Policy ○ Medication Error Review Committee minutes Medication Variances Analysis Reports and Plan of Correction ○ Specialty RN Meeting Summary dated July 14,2009 ○ Nurse Manager Meeting Reports ○ Nurse Staffing Report ○ Pharmacy Surveys and QI ○ Pharmacy/Therapeutics Committee reports ○ Individual records; as indicated below, many were chosen to sample across various conditions • Individual #30 • Individual #104 – pain management • Individual #432 – death record review • Individual #406 • Individual #397 – chronic care • Individual #544 – aspiration • Individual #55 – death record review • Individual #253 – pain management • Individual #308 • Individual #6 • Individual #352

	• Individual #130 – aspiration • Individual #542 • Individual #488 – pain management • Individual #515 • Individual #83 – chronic care • Individual #599 – diabetes management • Individual #3 – weight loss • Individual #14 • Individual #572 – pain management and hospice • Individual #493 • Individual #469 – psychotropic medications • Individual #59 – medication administration • Individual #24 – psychotropic medications • Individual #511 – seizures, hospitalization, emergency room • Individual #223 • Individual #279 • Individual #385 – psychotropic medications • Individual #188 • Individual #300 • Individual #517 – diabetes management • Individual #422 • Individual #96 – diabetes management • Individual #438 – weight loss • Individual #405 – seizures • Individual #541 – seizures • Individual #498 • Individual #138 • Individual #95 – aspiration • Individual #501 – diabetes management, seizures • Individual #523 <u>Interviews and Meetings Held</u>: ○ Chief Nurse Executive, Norris Buchmeyer ○ Nurses Meeting ○ Infection Control Nurse, Mary Jane Cotton ○ Nurse Educator, Paulette Caldwell ○ Nurse managers ○ Pharmacist, Dr. Matthew Okoro ○ Hospital Liaison, Rosemary Roberts ○ Nursing Operations Officer, Alice Robbins ○ Quality Assurance Nurse, Karen Wilson

	<u>Observations Conducted</u>: o Medication Pass Observations • Tuesday 03/23/2010 at 11:30am • Tuesday, 03/23/2010 at 3:30pm • Wednesday, 03/24/2010 at 4:00pm
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The nursing department at MSSLC had strong leadership and a staff of managers who had worked at the facility for many years. There were 140 nurses on staff. A number of additional RNII positions were added in the last year. Medication aide positions were discontinued simultaneously and this left the facility with a shortage of LVN staff to administer medications. The facility relied on agency LVNs extensively to administer medications. This resulted in medication errors that were significantly higher than those of the full-time staff. A number of medication passes were observed that were completed by agency staff, and there was not an error free pass in the four that passes that were observed. The nurse managers were candid about the challenges required to move in the direction of the requirements of the Settlement Agreement and Health Care Guidelines, but were equally positive that they could meet these requirement given enough time and assistance. In an interview with the Nurse Educator, the monitoring team learned that nurses in the facility had a long way to go in understanding the nursing process, which was central to the nursing portion of the Settlement Agreement and Health Care Guidelines. All nurses participated in the two week pre-service training required of all staff, and then were placed with a nurse mentor. A competency checklist was completed on each nurse before being assigned to a living unit. At least annually, nurses were required to prove their competency at a skill fair. This was implemented as a standard requirement for all facilities, but had been implemented only recently. Skills in head-to-toe nursing assessment have yet to be made a part of this system. The Nursing Operations Officer managed the day-to-day operations and assignments for about 130 nurses (RN and LVN). In addition, she was responsible for four to five nurses per day coming from about 60 different nursing agencies in the area. The Chief Nurse Executive supervised her, the nurse specialty positions (Hospital Liaison, Infection Control, Quality Enhancement (with the QA department)), Nursing Education, and the Nurse Recruiter. Minimum nursing ratios for the first two shifts were 25 for the first shift, and 27 for the second shift. She stated that 58 new positions were added about September of 2007, but most were RNII positions. When these positions were added, the medication aide positions were discontinued. She currently had four open positions for direct care nurses, but the use of agency nurses for medication administration was very concerning. Even though these nurses had to complete the same

	training as the full-time nursing staff, she believed that the commitment was just not the same. A disproportional number of medication errors were committed by these nurses. The Nursing Operations Officer was also responsible for the Nurse Managers who supervised the work of the Nurse Case Managers and the direct care nurses on each unit. There was a minimum nursing staff ratio on each unit, and agency nurses were used to cover when minimums were not met. The Quality Assurance Nurse had 30 years of experience in the facility and had been in this position since November of 2007. While she reported directly to the QA director, she also had a clinical relationship with the Chief Nurse Executive. She reviewed nursing documentation and process of about 14 records per quarter and specifically reviewed a number of sections of the facility's plan of improvement. She also completed death reviews for the two individuals who died this year prior to the on-site tour, and will complete the death review of the one individual who died during the week of the on-site tour. These were required to be done within 10 working days of the death. The QA nurse reported her observational findings to the Nursing Department, but had little to no time to return to monitor the areas that were out of compliance with the facility's plan of improvement. Another issue for her was the difficulty of accessing the record to complete the frequent documentation reviews. She may require additional training and the facility should assess this.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	There were many positives observed in this facility in the area of nursing administration and other services. The addition of nursing positions allowed the facility to add a Nurse Recruiter, a Wound Care Specialist, and RNIIs to assist the Case Manager Nurses. The Nursing Operations Officer worked at the facility for many years and appeared to have extensive knowledge of the areas for which she was responsible and, moreover, was well respected by all of her staff. The Quality Assurance Nurse did not report to the Nursing Department, but had a very close working relationship within that department and this enhanced the ability of QA to have a positive and efficient feedback to the nursing department regarding departmental and staff performance (though more work needed to be done as indicated below). Infection Control was another positive in this facility and the person who was in charge of this section was very passionate about her job. She was evidently "thinking outside of the box" when it came to investigations of both individual and staff infections as well as products that assisted in killing bacteria, particularly for MRSA. For example, she was very vehement about finding medications that would keep individuals from being admitted to acute care settings because these facilities were often responsible for producing the most difficult to control infections. Perhaps as a result, the facility had only two confirmed cases of MRSA, and one of these was newly identified.	

#	Provision	Assessment of Status	Compliance
		The Hospital Liaison Nurse was a position that was initiated two years ago. The nurse in this position was also the contract manager for 36 contract positions, the Cycled Waste Program, and two pharmacy contracts. This was a set of inherited responsibilities that were difficult to manage given her other responsibilities. She had an average of four individuals in four different acute care settings at any given time, including Scott and White Hospital, Waco Hospital, and Austin State Hospital. She visited each individual at least weekly, collected information from the acute care physicians, and kept the MSSLC physicians informed of the individual's status. This included collecting medical record information for each individual. There had been some communication issues with Parkview Hospital, in particular. For example, one individual was discharged back to the facility from the Intensive Care Unit. This individual had to be readmitted within a few hours. <u>Nursing Activities</u>: Overall, the monitoring team found that direct care nurses were extensively involved in daily care of individuals. Nurses had responsibility for the nursing care plans. These were incorporated into the PSP as a separate document, but more integrated clinical collaboration was needed. For example: • There was little evidence in the Acute and Chronic Health Care Plans that the issues that impacted on the two most common health care issues in the facility, aspiration and GERD, included collaboration with therapists regarding positioning to facilitate emptying and to prevent reflux. The Chronic Care Plans all referred to "elevating the head of the bed," rather than referring to "Elevate the individual's head and trunk in alignment to at least 45 degrees," which would have been a reflection of interdisciplinary collaboration. Nursing care plans were updated either on return from an acute care setting or quarterly at the time of the annual and quarterly reviews. For example: • In the 42 records reviewed, there was not a single individual for whom acute care plans following return from the hospital, or chronic Nursing Care Plans, were not present in the record. It was evident that the nurses documented all communication with the PCPs and PSTs. The nurses also were to document communication with direct care professionals, but this was not always present in the records reviewed. For example: • Individual #95 had three seizures on 2/23/10 that were not documented on the seizure record. There was no documentation that direct care professionals had been instructed on when to notify the nurse should these closely occurring	

#	Provision	Assessment of Status	Compliance
		seizures continue. Data from systems assessment on Annual and Quarterly Nursing Assessments were sometimes not included in Health Care Plans. When a nurse completes a full physical assessment, he or she assesses by body system, such as neurological, GI, respiratory, and so on. If the individual presents with significant issues in one of these body systems, then the care plan should reflect that with a nursing diagnosis and a plan to address that issue. For instance, if an individual had a hospitalization for GERD followed by Insertion of a G-tube, there would be a Nursing Diagnosis, such as Alteration in Nutrition, less than body requirements. <u>Documentation</u>: Documentation was inconsistent in meeting the requirements of the settlement agreement and the Health Care Guidelines. There was a range of nursing assessment and documentation skills demonstrated by the record review. Several records demonstrated excellent examples of full nursing assessment using the SOAP format. Other entries were simple one or two line entries. There were many irrelevant entries in the progress notes. Moreover, most of these did not fit into the SOAP format (e.g., "checked and changed and up in chair"). Further, most of the time, these entries obstructed important information in the record. Training and development was needed in this area. Many of the nurses needed training in head to toe assessment, SOAP documentation, full vital signs, and nursing process. Further, there was inconsistent completion of nursing entries, particularly for response to PRN medication. • Individual #501 had many entries that included SOAP notes along with a head to toe assessment with appropriate interventions. Interventions for her bowel issues, however, should have included abdominal girth measures. Abdominal assessment in the presence of active symptoms did not yet include the presence of hyperactive bowel sounds that can be indicative of an early small bowel obstruction. • Individual #405 had a number of entries that were not in SOAP format. This process was very inconsistent in the facility. The P of Plan most often said, "will monitor" without being specific about what, when and how. • Individual #95 had irrelevant entries, and few SOAP notes. Entries such as "check and change," "Received report from LVN," and "Individual #95 received daily bath and grooming session; Check and Change performed." These were entries that obscured important information and belonged somewhere else, such as on a flow sheet. • Few SOAP progress notes contained anything in the P section other than, "Will continue to observe".	

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		Nursing entries were inconsistent in legibility, with entries often difficult to read. Nursing quarterly reviews were comprehensive and well done. Late entries were labeled as such the majority of the time. Documentation of new treatments was consistently documented. Documentation of completion of treatment was done fairly consistently.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	There were both annual and quarterly nursing assessments universally present for all the individuals reviewed. These assessments seemed comprehensive and complete. The assessments, however, could have been simplified so that they did not require such an enormous amount of time for nurse case managers. Annual assessments required six to seven hours each to complete and quarterly assessments required three to four hours each.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Nursing interventions were primarily based on those that can be found in nursing protocols for a population without disabilities, that is, protocols were not adapted or specialized for this population. There are many issues with a population with complex disabilities and limited communication skills that needed development in this facility. Whenever an individual had an issue with stomach emptying, reflux, or respiratory problems, the intervention was written as: "Elevate the head of the bed." This was insufficient for individuals with the type of severe support needs who will possibly end up in an uncomfortable and perhaps dangerous position. Instead, the required position for the individual needs to be described. For example, "The individual should be positioned at 30 to 45 degrees with the head and trunk in alignment and the nose, naval, and knees pointing in the same direction." <u>Acute care</u>: Acute care plans were consistently completed, but were missing some of the steps that were appropriate for individuals with complex disabilities and communication programs. Nurses regularly assessed the individual if there was acute illness. This item was consistently complete in the records reviewed. Moreover, PCPs were consistently informed of the individual's status and documentation reflected fairly consistent evidence of nurse monitoring. Nursing staff informed other nursing and direct care professionals of the individual's condition. It appeared to be done through the change of shift report and other mechanisms, but was not evident in the record of the individual.	

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		A "continuous movement record" was available electronically and tracked movement in and out of acute care settings from 3/1/09 to the time of this on-site monitoring visit. The nurse liaison met daily with the facility physicians to report on the status of individuals who were in acute care. This position has done much to assure the health and safety of individuals in acute care settings. <u>Preventive care</u>: Prevention plans were reviewed for all individuals in the sample. The prevention plans for the men and women in the facility were up to date and meet the generally accepted professional standard of care. Specific routine screenings were completed on all individuals. These included mammography for all women according to recommended practice; colonoscopy completed routinely for most individuals in the sample reviewed; and prostate exams, PSA screenings, Pap test, and pelvic exams according to typical recommended practice. <u>Chronic conditions</u>: Nursing management of chronic conditions was adequate at this facility. • Hypertension was managed by the physician and was monitored by the nurses on a routine basis. • GERD: GERD and aspiration are two closely related health care outcomes that demand interdisciplinary collaboration to assure that at risk individuals have positions that prevent the problem from occurring or worsening. GERD often leads to aspiration because the individual is in a position that prevents emptying of the stomach and facilitates reflux. Elevating the head of the bed is often not a functional intervention for a number of reasons. First, the individual should not be in the bed for more than eight to 10 hours at a time. Second, elevating the head of the bed must be combined with assuring the quality of the individual's position. For example, the order should state: "Assure that the individual is elevated at all times to at least 30-45 degrees with the head and trunk in alignment and the nose, naval and knees pointing in the same direction." When sitting, the individual should be positioned with the pelvis in a slight anterior tile, with support to the forearms, such that the head and trunk are elongated, and the head is in neutral or slight capital flexion. During medication pass observations, the majority of individuals in Martin were observed sitting on their tailbones or low back with their heads in extension. This dropped the trunk on the diaphragm and often encouraged backward flow from the stomach. Other individuals were observed sitting with their heads far behind neutral, leaving the airway open and facilitating aspiration both during swallowing as well as during any reflux occurring because the stomach has difficulty emptying	

#	Provision	Assessment of Status	Compliance
		when an individual is sitting in a posterior pelvic tilt. Nurses will have difficulty addressing these issues without interdisciplinary collaboration with the habilitation therapy department. o The nursing care plans for #405 repeatedly referred to elevating his head to 30 degrees at all times. His head was fixed in about 20 degrees of extension and his bed was no higher than 20 degrees. This intervention was unrealistic and required assistance from a therapist to implement. No evidence of such interdisciplinary collaboration was documented. The GERD plan said "elevate head 45 degrees during and for 1 hour after eating. This individual was on a continuous pump. The Trachea/Respiratory distress plan said "keep head of bed elevated 30 degrees at all times." • Weight: Maintaining individual's appropriate exercise and proper body weight were a challenge at the facility. Staff would benefit from assistance from the psychology, habilitation, and education departments. Individuals who were overweight were monitored weekly to monthly. • Urinary tract infections: The most frequent issue for the facility was the frequency of fecal contamination. The nursing care plans did not reflect training of DCPs to avoid care practices that can cause contamination of the urinary tract. Urinary Tract infections, particularly those documented as E.coli, are most often a reflection of perineal care that is done incorrectly. When the individual, particularly a female, is not cleaned correctly, the rate of UTIs escalates. Little evidence was found in the care plans that this issue was appreciated at all, particularly for those individuals who were totally dependent upon others for their care. Nurses should include routine monitoring of DCP check and change routines as a part of the individual's care plan to assure that DCP's basic technique is adequate. This is particularly important for individuals who have E.coli contamination documented in their health history. • Chronic respiratory illness: Nearly 40% of ER/acute care admissions were related to respiratory issues. A lot of work needed to be done in this area at the facility. There were repeated episodes of respiratory distress resulting in ER or hospitalizations, but little evidence that interdisciplinary staff was aware of this high percentage or that they were looking for root cause. Intervention was limited to handling signs and symptoms. This area was the most in need of interdisciplinary collaboration. • Bowel management: The low frequency of admission to acute care facilities for bowel issues reflects positively on the management of this issue. • Osteoporosis management: This was compromised for individuals with extensive physical complications and GERD due to the need for upright positioning for some persons who were incapable of doing this. For example: o Individual #95 had instructions for elevation to at least 30 degrees. He	

#	Provision	Assessment of Status	Compliance
		was incapable of doing this because his head was fixed to at least 20 degrees and he was positioned in his bed at no higher than 10 degrees, with his head 20 degrees behind that. Seizure management: Seizure Management at MSSLC consisted of a Seizure Record, which documented an event along with what occurred before, if known, during, and after the seizure (via a checklist); the time the nurse was notified; and what measures were taken, including vital signs. Nurses were also required to document in the IPN (integrated progress notes) in a SOAP format including the plan for follow-up. • There was a "Seizure Documentation Sheet" which documented the time, duration, and intensity of seizures, along with a symptom checklist. The intervention and time of arrival of the nurse (both LVN and RN) was also recorded and was completed fairly consistently. Emergency medication or other treatments were also documented consistently in the records reviewed. • Seizures were recorded on a seizure record that included descriptions of the event and the time the nurse arrived to assess. This was done consistently on most of the records reviewed. • Documentation of seizures presents a special management problem when individuals have more than one type. Individuals with seizure syndromes, such as West Syndrome or Lennox Gestaut Syndrome, could have four or five distinct types of seizures. The recording form used by the nursing department did not allow the physician to discriminate which seizure type was present and at what frequency. While seizures were consistently documented, other formats that allow for more discrimination should be explored and considered by the facility. An example would be to have a behavioral description of each type of seizure and translate this into a scatter plot that gives the physician specific information about the type, frequency, and time of day. • Individual #405 had extended seizures on 2/12/10, with a seizure sheet completed. In addition, there were extensive notes describing the seizure activity and the individual's response to the Diastat given, notification of the physician, and transfer to ER. Individual #405 had numerous seizures each day, however, the seizures were not described in the care plan. Pain management: The facility had, for the cases reviewed, done an adequate job of assessing and managing pain. Several individuals were being managed with terminal cancer, and pain management plans were supported with hospice intervention. Training instructions for staff were present on every health care plan, but sometimes were missing needed steps. For example: • Individual #471 was being managed by hospice due to Stage 4 liver cancer. He	

#	Provision	Assessment of Status	Compliance
		was receiving good management of his end stage pain. Skin integrity: In a number of cases, skin integrity problems were identified in the record, but did not make it to the quarterly assessment. Nurses were assisted by the presence of a wound care nurse who assumed partial responsibility for all wounds. The Braden Scale was a part of all annual and quarterly assessments. The Braden Scale is the current tool used in most nursing care facilities to determine skin vulnerability. Psychotropic medications: The role of nursing in the use and management of psychotropics seemed to be focused on health care issues related to things, such as weight management, side effects of medications, and so forth. While there was participation in the meetings that addressed these issues, there was no evidence that nursing participated in this area to the degree required by the Settlement Agreement and the Health Care Guidelines.	
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.	Nursing assessments for annual and quarterly reviews were quite adequate, but assessment of acute conditions failed to meet the generally accepted professional standard of care required by the Settlement Agreement and the Health Care Guidelines. The standard of practice in nursing requires a full head-to-toe assessment with full vital signs whenever there is a change in condition or when there is a presentation of acute symptoms. Some examples are provided below: • Individual #501 was admitted to the hospital on 4/28/09 with symptoms of sigmoid volvulus and again on 5/14/09 for DVT, tachycardia, and pleural effusion (fluid on the lungs). Her health management plan did not address assessment when she presented with symptoms or specific indicators of ileus, nor did it include specific measures for direct care professionals reporting of change in condition, such as belly distension, refusing meals or complaints of discomfort and lethargy. She also had a plan for UTIs (Urinary Tract Infections), but it did not include instructions for staff regarding the appropriate ways to cleanse the perineum to avoid fecal contamination of the urinary tract. • For Individual #95, DCPs had individualized instructions for care of his gastrostomy tube, but there were no instructions for DCPs to report any feeding formula noted in the back of the throat or feeding formula smell on the breath. PEG tubes increase the risk of GERD rather than decrease it. This individual should also have been at 45 degrees of head and trunk elevation for at least 30 to 60 minutes following the weekly administration of Fosamax, which was not noted in the health care plan.	

#	Provision	Assessment of Status	Compliance
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	Please see section I of this report.	
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.	Medication administration at MSSLC was accomplished on two shifts in each unit at least four or more times a day. Medication aides were previously responsible for the majority of drugs administered, with the exception of those medications given via a route other than orally. Within the last two years, the state mandated that only licensed personnel could administer medications. Therefore, Medication Aide positions were discontinued. When additional nurses were authorized, only RNII level positions were authorized, and for specific reasons, such as assisting Nurse Case Managers. Due to the shortage of LVNs in the facility, nursing agency LVNs were hired. Medication Administration Records were being reviewed by the Nurse Manager on a one or two week schedule. That meant that each nurse managers checked each Medication Administration Record for the individuals in her area at that frequency. There were problems regarding the current process of reviewing the MARs (Medication Administration Records) every one to two weeks. When holes in the MARs were discovered, the offending nurse was given the opportunity to fill in the missing initials without the event being considered a medication error. This was a practice that was not in line with current nursing practice standards. Only a few holes were found in the MARs, probably due to this practice. In a few repeated instances, a square was drawn around the signature space with initials in different types of ink. This was a dangerous practice, since it would have been difficult to remember after two weeks if the medication was given or not. Medication Pass Observations were completed in the following areas: • Tuesday 03/23/2010 at 11:30am in Martin • Tuesday, 03/23/2010 at 3:30pm in Longhorn • Wednesday, 03/24/2010 at 4:00pm in Whiterock In two of the three areas where medication administration was observed, the nurses	

#	Provision	Assessment of Status	Compliance
		were from a staffing agency. During these observations, there were numerous errors, including documentation completed before administering the medication, failure to check for placement and residual for an individual with an enteral tube, and violating agency protocol for hand washing. There was only one error free medication pass completed by the five or six agency nurses that I observed. The medication pass in Longhorn with a full time staff nurse included self-administration of medication (SAM) that was simple and error free. The QA nurse completed medication pass reviews weekly. Also, an issue for this process was the setting up of medication for both the 4 p.m. and 8 p.m. medication passes. Standard of practice calls for medication to be set up as it is being passed. Setting up medications for two shifts in advance violated this generally accepted professional standard of care.	

Recommendations:

1. The facility should attempt to hire sufficient LVNs to prevent the need for the current situation of five or six FTEs of these positions being filled by agency LVN staff.

2. Review of MARs should be at least weekly. Any failure of documentation should be reported as a medication error.

3. Assess error rates for medication administration, especially for agency provided nurses.

4. Nurses should demonstrate competence in head to toe physical assessment at least annually, and be trained and held to the current standard of practice.

5. When individuals have documented hiatal hernias, the procedure for checking for residual should be modified to assure that the individual's trunk is elongated prior to the residual check.

6. Improve nursing care for GERD, respiratory issues, and UTIs. Please see comments above in section M3.

7. Ensure QA nurse has ability and training to access records and meet with nursing department to provide feedback.

8. Pursue nursing collaborative integration in PSP planning and communication across disciplines and departments at the facility.

9. Ensure appropriate nursing participation in review of psychotropic medications.

10. Tighten up nursing documentation, including SOAP. Improve legibility of nursing record entries.

11. Review the workload and responsibilities of the hospital liaison nurse.

12. Admissions assessments need to be more comprehensive.

13. Ensure medications are not set up for passing prior to the time of administration.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Reviewed Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines Interviews and Meetings Held: o Matthew Okoro, Director of Pharmacy o Dr. Dolores Erfe, Medical Director Observations Conducted: o Medication Pass Observations • Tuesday 03/23/2010 at 11:30am • Tuesday, 03/23/2010 at 3:30pm • Wednesday, 03/24/2010 at 4:00pm
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The facility had been relying on a Locum Tenens (temporary substitute) Doctor of Pharmacology until the hiring of Dr. Matthew Koro five months prior to this on-site tour. While medication reviews for all individuals had been completed over the last year, many of the review processes, such as Drug Reviews, were only beginning to occur. The electronic management system was very primitive and not suitable for the drug interaction reviews that were necessary for meeting the generally accepted professional standard of care as defined in this section of the Settlement Agreement. Most of the actions required by this provision were either newly developed or underdeveloped and, therefore, incomplete.

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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	The requirements of this provision item were occurring, and were also related to all medications in addition to newly prescribed medications, but because they were recently implemented, they were not well developed. Most of the clinical pharmacy reviews in the record were signed by both the physician and pharmacist, but there was no indication on the form, other than a signature, that the physician was considering the	

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	conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	pharmacy recommendations or observations. At MSSLC, a Pharm.D. who was in a "Locum Tenens" position, was responsible for completing clinical reviews. The form used to complete this process was provided by the state. There was a quarterly drug regimen review by a committee consisting of the physician, pharmacist, nurse, and sometimes others, such as the psychologist.	
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.	This process had begun, but was hampered by the lack of an electronic system typically used by most pharmacists to evaluate these issues based on the particular drug regimen of each individual. There were 450 individuals living at this facility, many of whom who were receiving as many as 12 to 15 different medications. Meeting the requirements of this provision item is not likely to be possible without sufficient electronic support.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and	As system for monitoring emergency "stat" medications, chemical restraints, and the use of benzodiazepines, anticholinergics, polypharmacy, and antipsychotic medications was not yet operational during the time of this on-site tour. This will be assessed during upcoming on-site monitoring tours.	

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	endocrine risks associated with the use of new generation antipsychotic medications.		
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Medical practitioner consideration of pharmacist recommendations was not yet evident in any of the records reviewed.	
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.	Nurses did Quarterly TD and DISCUS assessments and these were submitted to the physician for review. It was not clear whether, or how, these assessment tools were used by the treating physician and/or psychiatrist.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The medical director reported that there had been no adverse drug reactions. Further review of this provision item will occur during upcoming on-site monitoring tours.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing	The process of regular drug utilization evaluations had recently begun by the Pharmacy Director and will be more thoroughly evaluated during upcoming monitoring team visits.	

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	compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.		
N8	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.	There was no indication that the facility was engaging in any actions regarding medication variances.	

Recommendations:

1. Implement actions to address each of the items in this provision of the Settlement Agreement.
2. Integrate pharmacy and pharmacist activities into the provision of services as required throughout the provision of the Settlement Agreement.
3. Consider using an electronic pharmacy system.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o Current Census Alpha o Common Elements of Physical and Nutritional Management o Applicable standards identified as Health Care Guidelines Section VI-Nutritional Management Planning and Section VIII-Physical Management o Physical Nutritional Management policy #012, 12/17/09 o Nutritional Management Policy #013, 12/17/09 o At-Risk Individuals Policy #006, 10/05/09 o Handbook, Habilitation Therapies Physical Nutritional Management, by Karen Hardwick, Ph.D., OTR, FAOTA (September 2007) o Best Practice Guidelines (July 2008) o Positioning Wheelchair Data Base dated 03/04/10 o CVs for PNMT members o Continuing Education Records for PNMT members o PNM Clinic assessment worksheet o Wheelchair/Related Equipment Work order form o Occupational Therapy Functional Eating Skills Assessment worksheet o Occupational Therapy Baseline Evaluation worksheet o Habilitation Therapy Services, dated 02/22/10 o Habilitation Therapy Services Database, 02/19/10 o List of Individuals with Other Ambulation Devices o List of Individuals with Orthotics and/or Braces o List of Individuals Who Used Wheelchairs as Primary Mobility o List of Individuals with Transport Wheelchairs o OT/PT Evaluations for the following: • Individual #231, Individual #165, Individual #451, Individual #494, Individual #401, Individual #438, Individual #6, Individual #352, Individual #227, and Individual #454 o OT/PT Evaluations, worksheets and documentation related to wheelchairs for the following: • Individual #177, Individual #494, Individual #231, Individual #451, and Individual #401 o PNMP format o Completed PNMPs submitted o Dining Plan format o Departmental audits dated 08/25/09 and 01/06/10 by Margaret Farrington, PNM Director o Occupational/Physical Therapy Services #014P, 11/04/09 o Audits by Margaret Farrington o Staff New Employee training curriculum Functional Eating Skills, Functional Dining Skills , Lifting,

	and Occupational Therapy Pre-service Training o Sample positioning plan for • Individual #511 o List of individuals who had experienced a falling incident during the past three months o Personal Record documents including: Personal Support Plans and addendums, Annual Medical Summaries, Nursing Annual and Quarterly Assessments for the last year, QMRP monthly reviews for last 12 months, NMT reports and screenings, Health Risk Assessment Tool, OT/PT Assessments and treatment notes, OT/PT Assessments/Updates and treatment notes (only assessment for Individual #405, dated 03/02/10, was submitted), OT/PT/SLP Consults, Modified Barium Swallow Study reports for the following individuals: • Individual #544, Individual #513, Individual #560, Individual #511, Individual #501, Individual #488, Individual #481, Individual #47, Individual #438, Individual #390, Individual #216, Individual #40 Individual #30, Individual #411, Individual #397, Individual #119, Individual #588, Individual #375, Individual #439, and Individual #77 o NMT meeting minutes (03/03/09 – 01/21/10) o Nutritional Management Screening Tool o Health Risk Screening Tools and At-Risk lists o Nutrition Services data base for weight and BMI o Nutritional Management Data Base o QA Tools for PNM completed by Kim Kirgan o List of individuals diagnosed with pneumonia o Policy Client Management – 34 Reporting Choking Incidents (03/16/10) o List of choking incidents 07/09 – 02/10 o Pressure Wounds (2009 to March 2010) o Osteoporosis/Osteopenia Diagnosis and T-Scores o Dining Plans o Diet Order list o Training rosters for PNM-related inservice training o List of individuals see in the ER and Hospitalization list o Mealtime related records for Individual #546 o NMT Consultation Summaries for • Individual #256, Individual #509, Individual #41, Individual #75, Individual #212, and Individual #164 o PNMP Observation Sheets o Meal Observation Sheets Interviews and Meetings Held: o Coleen Range, MS, CCC-A, Director of Habilitation Therapies o Cara Mattson, MA, CCC-SLP o Jean Reboli, MS, CCC/SLP o Kim Henderson, MS, CCC-SLP o Anita Lane, M.Ed., OTR

	○ Doris Ricketts, MBA, OTR ○ Sandra Opersteny, PT ○ Sandy Leggett, PT ○ Lisa Finley, COTA ○ Jennifer Capers, RD ○ Carey Perkins, RD, Chief Dietitian ○ Sheila Fulmer, Food Service Director ○ Cassandra Chambers, Kitchen Manager ○ LaSonya Griffin, Dining Rooms Manager ○ Margaret Farrington, OTR, PNM Director ○ Pamela Harlan, COTA, PNM Department ○ Kim Kirgan, QA ○ Discussions with various supervisors and direct care professionals ○ Discussions with various day program staff Observations Conducted: ○ Mealtimes ○ Living areas and day program areas ○ Seating simulation, cancelled after the individual wanted to go to Easter parade ○ PNMP Clinic – Thomas Pickett ○ Weekly Webinar
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: MSSLC had a system of PNM supports and services that included a group that met monthly to address a variety of PNM concerns. The NMT documented consistent participation by physicians and nurses, but less than acceptable attendance by core team members, such as the SLP and PNM Director. Some team members had background, experience, and continuing education, but this was not available to each of those participating on the NMT. Documentation was well organized, readily identifying PNM issues and status based on extensive record review by OTs prior to the meetings. Follow-up was inconsistent and risk levels were decreased quickly without sufficient time for individuals to maintain a stable health status. With a decreased risk, frequency of review was also reduced for many individuals who continued to be at risk and who would have benefitted from closer monitoring by the NMT. The current systems intended to assign and manage risk issues were not coordinated and integrated; they functioned in a parallel manner. Assignment of risk did not consider thresholds and outcomes related to recommendations and interventions. A number of individuals were listed at medium or low risk for aspiration, choking, osteoporosis, and skin breakdown when, in fact, they had actual diagnoses in these

	areas. A number of issues were observed by the monitoring team to indicate that PNMPs were not consistently and properly implemented. Staff training was not competency-based and monitoring did not occur with sufficient frequency to ensure that staff compliance was routine. The existing monitoring methods were evolving at the time of this review, but plans were not in place to use risk levels to drive the intensity and frequency of PNMP monitoring. There was also no plan in place to track and trend findings to permit targeted and timely staff training. The existing monitors did not demonstrate sufficient competency to ensure that individuals were closely monitored and that there was sufficient compliance with implementation of critical PNM supports as outlined in the PNMPs and dining plans. As described throughout this review, there were numerous examples of inadequate implementation of these plans by staff. The current system of monitoring was ineffective in the identification and remediation of these errors and this put individuals at risk of harm for aspiration and/or choking, and increased the potential for tube placement.

#	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	PNM team consists of qualified SLP, OT, PT, RD and as needed, consultation with MD, PA, RNP. The current state-approved policy, dated 12/09/09, stated "the NMT is typically comprised of the: a. Physician; b. Occupational Therapist (OT); c. Speech Language Pathologist (SLP); d. Registered Nurse (RN); e. Dietician; and f. Other disciplines as indicated by need including but not limited to Physical Therapy, Certified Occupational Therapy Assistant, Licensed Vocational Nurse (LVN), psychologist, QMRP, home staff, and others." The purpose of the Nutritional Management Team was to: 1. Identify individuals at risk for dysphagia/aspiration; 2. Ensure individuals received adequate nutritional intake; 3. Decrease instances of choking/aspiration; 4. Decrease health problems secondary to aspiration; 5. Identify individuals with gastroesophageal reflux and other gastrointestinal (GI) conditions; 6. Make evaluation and treatment recommendations; 7. Provide training to staff in Nutritional Management issues; and 8. To conduct other activities as appropriate to ensure safe eating and adequate physical and nutritional health. A PNM team was in place at MSSLC. There was no meeting conducted the week of the on-site baseline review. Membership included SLP, OT, Primary Physician, RN Case Manager, dietitian, and PT, only as needed. This group at MSSLC was referred to as the Nutritional Management Team. NMT meeting minutes were submitted for meetings held from March 2009 through January 2010. A meeting was held each month during the past year with two conducted in April. Members were listed as follows:	

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<tr><td></td><td>input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.</td><td>

Lisa Finley BAS, COTA, Committee Chairperson
Dolores Erfe, MD
Anita Lane, OTR
Keri Perkins, RD, LD
Rosemary Roberts, RN
Kim Henderson, SLP
Margaret Farrington, PNM Director, OTR (listed as a member since July 2009)

Attendance was recorded for each meeting and included "members absent" and non-members present. Non-members were listed as of the May 2009 meeting. It was presumed if a member was not listed as absent, his or her name on the members' list was indication that he or she was present as there was no actual designation of "members present." There was no start and stop time so the length of each meeting was not known. Attendance was documented as follows:

Member Physician: 7/12 meetings
Non-Member Physician/Assistant: Average 2.34
PNM Director: 1/7 meetings
Member SLP: 6/12 meetings
Non-Member SLP: 2/12 meetings
Member OTR: 12/12 meetings
Non-Member COTA: 2/12 meetings
Member RN: 9/12 meetings
Non-member RN: Average 9
RD: 11/12 meetings
QA: 1/12 meetings

There was no evidence that PT or psychology participated in any of the meetings held in the last year. It was of concern that that the PNM Director had only attended one meeting since listed as a member beginning in June 2009 and the Member SLP had only attended 50% of the meetings. While a non-member SLP attended two meetings, they were meetings also attended by the Member SLP rather than as a designee. While the Member Physician and RN did not attend each meeting, there were numerous others that attended every meeting.
<u>There is documentation that members of the PNM team have specialized training or experience in which they have demonstrated competence in working with individuals with complex physical and nutritional management need</u>. Resumes/CVs for team members were submitted as requested, including Kim Henderson, MA, CCC-SLP; Lisa Finley, BAS, COTA; and Anita Lane, M.Ed. A resume for Stacy Catero, a speech language
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		pathologist was submitted, but she was not listed as a member and was not employed as an SLP at the time of the on-site review by the monitoring team. No others were submitted for the team members listed in the meeting minutes. While additional resumes were submitted for other clinical staff, none of these had attended a meeting of the NMT in the last year per the meeting minutes, though some conducted assessments in the PNMP/Wheelchair Clinic. Credentials for Keri Perkins from the Commission on Dietetic Registration certified that she was a registered dietitian since 10/01/1985. No other credentialing documentation was submitted for team members. Lists of continuing education for team members were submitted. PNM-related continuing education for the last two years was as follows: • The Chairperson, Lisa Finley, documented that she had practiced as a COTA since 1997. She had worked at MSSLC since that time. She had attended PNMP/Wheelchair Clinic in summer 2009 and September 2009. She also attended "The Art of Performing Seating and Mobility Evaluations" in October 2009 and other sensory-related courses. As a COTA, Ms. Finley was not licensed to conduct assessment and develop treatment plans. State practice acts dictate that a COTA work under the supervision of an OTR. • Anita Lane, the OTR member of the NMT, documented that she had practiced as an occupational therapist since 1968 with approximately 15 years at MSLLC off and on since 1975. She listed attendance at the PNMP/Wheelchair Clinic in summer 2009 and September 2009 and the DADS-sponsored Habilitation Therapies Annual Conference in 2008 and 2009. She also listed "Seating and Mobility Systems for Individuals with Developmental Disabilities" in October 2008 and other sensory-related courses. • Kim Henderson, the SLP member of the NMT, documented that she had practiced as a speech-language pathologist for 24 years in the public school setting and five years in a residential care setting for people with developmental disabilities (she had reported in interview that she had worked at MSSLC for five and a half years) and one year in a senior residential care setting. She received her BA in Speech pathology in 1980 and her Masters in Communication Disorders recently in 2008. She listed attendance at "PNMP for SLP and Augmentative Communication" (04/29/09 and 07/29/09), "Physical and Nutritional Management for SLPs", "Issues in Evaluation and Treatment of Individuals with Developmental Disabilities," and other communication-related courses. • A list of Continuing Medical Education activities was submitted for some of the physicians who attended NMT meetings (i.e., Dr. Christopher Ellis, Dr. Victor Vines, Dr. Daisha Hayden, Dr. Jose Ruiz-Cales), though only Dr. Ellis and Dr. Hayden were listed as attendees at the NMT meetings. There was no evidence that the other two physicians had participated in these meetings. Rather, Dr.	

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		Daniel Crain, Dr. Ji Sun Lee, and William Thomas, PA attended the NMT meetings. There was no evidence of continuing education for Keri Perkins, RD, LD; Rosemary Roberts, RN; and Margaret Farrington, OTR who served as core members of the NMT. Additional lists of continuing education were submitted for other clinical staff, but they had not attended any meetings of the NMT in the last year, though some of them conducted assessments in the PNMP/Wheelchair Clinic. State policy identified that "each regular member of the NMT should complete ongoing training in the area of physical and nutritional management for persons with developmental disabilities." There was no indication that MSSLC had a plan for training and, therefore, all NMT members were not receiving any ongoing training specific to their duties and responsibilities on this team. <u>PNM team meets regularly to address change in status, assessments, clinical data and monitoring results</u>. Per state policy, meetings were to be held at least monthly, with additional meetings held related to the following: eating/health problems, changes in risk level by the HST, after esophagrams or other medical or diagnostic tests, before finalizing treatment decisions, to address follow up activities, and at any phase in the Nutritional Management process. Meeting minutes were submitted with evidence that the NMT met at least monthly since March 2009 through January 2010. Documentation was maintained by Lisa Finley, COTA, the chairperson. The agenda of individuals reviewed by the NMT was determined by Ms. Finley based on extensive chart review. It was of concern that she was expected to make clinical judgments of this nature. During the interview, she had difficulty presenting the role and function of the NMT and, as a result, her competence to fulfill the role of Chairperson as a COTA was in question. Per the meeting minutes, categories for review included: annual review; choking incident; follow up for aspiration, weight loss, and anemia; scheduled follow up; follow up post swallow study or other diagnostic testing; and others. The average number of individuals reviewed per meeting was 23, ranging from 16 to 38 individuals across these categories. Approximately 147 individuals were reviewed during the period for which meeting minutes were submitted. There were 26 individuals reviewed three or more times during that time. They included the following: Individual #95 (10), Individual #511 (10), Individual #411 (7), Individual #12 (6), Individual #438 (5), Individual #119 (5), Individual #439 (5), Individual #111 (5), Individual #216 (5), Individual #405 (5), Individual #48 (4), Individual #588 (4), Individual #41 (4), Individual #130 (4), and Individual #502 (4). There were 11 others seen on three occasions.	

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		Reason for review and NMT risk level was clearly stated for each individual, although there was no indication of previous reviews included in the meeting minutes. The minutes included a summary of the group discussion and disposition with recommendations were clearly documented. A specific plan for subsequent review was outlined in most cases, however, when a specific action was recommended, there was no subsequent follow up scheduled to evaluate effectiveness of the intervention. Some examples included: • Individual #448 – During her annual review by the NMT on 01/21/10, her enteral feedings were discontinued and her diet was changed to regular texture with staff to cut meat in front of her. She was to receive water only through the tube. She was assigned a Risk Level 2 and then scheduled for annual follow up only. There was no evidence that the NMT would review her to determine if this plan was effectively implemented. • Individual #41 – He was listed twice with choking events on 09/09/09 and 01/12/10, per the list submitted with the document request for choking events from 07/09 to 02/10. The entry by the NMT on 09/10/10 reported that the incident on 09/09/09 had been his third incident that year, each related to food stealing. At that time, there was discussion of placing trash cans with lids throughout his home to decrease the risk of him taking discarded food. Recommendations were to continue his current diet and supervision during all food-related activities. The PST was to "consider" placing trash cans with lids in his home and work area. His risk level was decreased from 1 to 2 and he was to be reviewed by the NMT annually. The NMT reviewed him again on 01/21/10, after another choking event (date again not recorded) in which he took a granola bar from a peer, requiring three abdominal thrusts to clear. The physician had ordered one-on-one supervision during food-related activities, but the team decided to recommend enhanced supervision during food-related activities instead. Though he had a "long history of choking incidents associated with food stealing behavior," the NMT decreased his risk level from 1 to 2 and scheduled annual follow up only. This decision was made after reviewing evidence of four choking incidents in the last year related to food stealing. There was no evidence of collaboration with psychology to address this concern though the Unit Director was now "in the process of purchasing trash cans with lids," nearly four months after the recommendation. There was evidence of one additional choking incident documented in the NMT minutes though Individual #41 was reviewed on two other occasions. He was reviewed on 03/03/09 following a swallow study on 02/25/09, though rationale for the study was unclear. Recommendations were to see him on an "as needed basis." He was seen again on 05/28/09, three weeks after a choking event on 05/06/09 and a swallow study on 05/08/09. Recommendations at that time were to provide staff training related to	

#	Provision	Assessment of Status	Compliance
		supervision during meals and other food related activities, change his dining plan to reflect this, and NMT review in one year or "sooner if necessary." Clearly, the supports for Individual #41 had been inadequate to ensure his safety with at least three documented choking events for the same reason, food stealing, in the last year. He continued to be at high risk of death by choking, yet the plan suggested by the NMT was essentially unchanged. • Individual #216 – The NMT conducted a review on 01/21/10 for follow up post-hospitalization in November 2009 due to aspiration pneumonia, approximately two months earlier. He had lost 2.5 pounds. By report, he had pulled out his tube numerous times and he wore an abdominal binder. His risk level was decreased from 1 to 2 and he was to be reviewed again in two months. Additional concerns for Individual #41 are outlined below. • Individual #493 – She was reviewed by the NMT on 12/15/09 after a swallow study (date not recorded) and she was upgraded to a chopped diet and regular thick liquids. The SLP was to supervise trials, but the NMT scheduled follow up in one year, decreasing her risk level from 1 to 2. • Individual #161 – She was seen following a choking incident and swallow study (dates not recorded) on 12/15/09. She was not identified on the list of choking incidents from 07/09 to 02/10, submitted by MSSLC. Her diet order was changed to ground and nectar thickened liquids (previous diet order not recorded). Staff were to alternate bites and sips. Her risk level was decreased from 1 to 2 and she would be reviewed by the NMT annually. The findings of PNMP monitoring were unknown to the NMT and as a result they were not used in the review of individuals with PNM risks. <u>PNM plans are incorporated into individuals' Personal Support Plans (PSPs)</u>. PNMPs were only marginally addressed in the PSPs reviewed. The PSPs reviewed reflected integration of the PNMP in the following ways: • PNM-related information was included in the Assessment section of the PSP under a variety of headings including Physical Medical, Nursing, Pharmacy, NMT, Nutrition, OT/Nutritional Management, Dining Plan, OT/PT, and Speech, though each of the headings were not included in each PSP. • The Assessment section of the PSP generally listed recommendations in each of these areas. • The General Discussion section of the PSP occasionally included a heading for PNMP/IACT and stated "These documents were reviewed and updates will be made as needed" or other similar statement to that effect. While there was some limited evidence of PST review and discussion of the PNMPs, they	

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		continued to appear as a habilitation therapies responsibility rather than that of the entire team. Identification, assessment, interventions, monitoring, and training as outlined in sections O-2 through O-8 as described below. See below.	
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.	A process is in place that identifies individuals with PNM concerns. Per the current policy implemented on 01/31/10, a Nutritional Management Screening Tool was utilized in the "discovery or referral phase" of the process to identify each individual's Nutritional Management Risk. Risk indicators were identified across three levels of risk: High (Level 1), Medium (Level 2), and Low (Level 3). Per the screening tool submitted by MSSLC, risk factors were for aspiration pneumonia, choking, weight loss, GERD, and so on. The screening focused predominately on nutritional management concerns and was very limited with regard to physical management concerns that may also impact health status, such as contractures, impaired skin integrity, and so forth. Identification of the risk level was intended to drive further assessment, intervention, and frequency of review of risk status. The NMT reviewed individuals with specific health risk concerns annually prior to his or her annual PSP meeting. The Nutritional Management Screening tool was completed annually at that time and subsequently when reviewed in the interim by the NMT. Personal record information was reviewed and the risk level was documented in the meeting minutes for that month. The screening tool was not administered in conjunction with the health status review checklists and the two were essentially not related to each other. The screening tool indicated that an individual at a Level 1 should be reviewed at the next scheduled meeting. A Level 2 designation warranted review in 30 days to one year, and the Level 3 designation warranted review as needed. The NMT began assigning risk levels to individuals they reviewed beginning with the June 2009 meeting per the minutes. All those with a Level 1 designation were scheduled to be seen in one month, but the NMT did not consistently follow its own policy to follow up on individuals based on their assigned risk level. Additionally, risk levels were often decreased quickly and before an individual had demonstrated a stable health status for a period of time. As a result, some individuals were not reviewed with sufficient frequency. Often, only another negative health outcome triggered subsequent review. • Individual #130 – He was reviewed on 08/13/09 and was scheduled for review in three months following a neurology consult. The discussion indicated that he was at a Risk Level 2, yet the disposition listed "Risk level 1." He was reviewed on 10/22/09 for "follow up after swallow study." He was considered to be at high risk for aspiration with severe dysphagia and PEG placement. He was reviewed	

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		again on 11/12/09, with the reason listed as "follow up peg placement." He was assigned a Risk Level 2 with subsequent review in two months. The review on 01/12/10 documented a weight gain of 11 pounds since tube placement and improved health status. He was recommended for annual review. There was no mention of the neurology consult in the discussion during those meetings. It was also of concern that he was only two months post tube placement and had not clearly established a stable health status at that time, yet his risk level had been decreased. • Individual #509 - She was reviewed on 03/03/09 for refusal to eat and follow up to a swallow study. By report, she had pulled out her tube and it was "left out," though the next sentence stated that she "has a tube for meal and medication refusals." The only recommendations were to continue with her current diet with NMT review on an annual basis. Risk levels were not assigned at that time. She was reviewed again on 09/10/09 for follow up after choking on medications (date not reported) and a swallow study. This study noted an increased level of dysphagia and it was recommended that medications be administered in pudding and her liquids be thickened to pudding consistency. The NMT recommendations were to continue a pureed diet with pudding thickened liquids. No recommendations were made related to medication administration. Her risk level was decreased from 1 to 2 with annual review, or as needed. She was scheduled to be reviewed in one month during the NMT meeting held on 12/15/09 when she was reviewed for follow up after an episode of aspiration pneumonia (date not recorded). A bedside evaluation by the Speech department had been ordered due to "several episodes of pneumonia since the gastrostomy tube was removed" and her risk level was increased from 2 to 1. As of the meeting held on 01/21/09, she had not been reviewed. It was of concern that the NMT did not recognize the continued risk of choking and pneumonia following the choking incident in September and waited until she had subsequent aspiration pneumonia before conducting further review. It was of even greater concern that she was not seen the next month as indicated per MSSLC policy and generally accepted practices. • Individual #216 was reviewed by the NMT five times during the period for which meeting minutes were submitted. He was scheduled to be reviewed in one month on two occasions due to his Level 1 risk, however this did not occur. He was seen on 09/10/09 and assigned a Risk Level 1 with review in one month related to follow up on PEG tube placement and swallow study on 08/14/09. The study was discontinued secondary to penetration and aspiration. He was scheduled for PEG tube placement on 09/21/09. He was to continue pureed texture with pudding thickened fluids. Staff were to assist him to eat to ensure small bites and sips. The nurse was to monitor for aspiration. Individual #216 was not reviewed by the NMT until 11/12/09, two months later. It was documented in the minutes	

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		that the scheduled PEG tube placement was not completed due to the discovery of three latex gloves "embedded in the stomach wall" which required surgical removal on 10/22/10, with tube placement at that time. He was discharged on 10/24/09, but returned to the hospital hours later with diagnosis of aspiration pneumonia. He was discharged on 11/10/09 with a 15 pound weight loss. He presented with issues related to residuals, GERD, and difficulties maintaining his head elevated in bed as well as a new diagnosis of congestive heart failure. He continued at a Level 1 with review scheduled again in one month. The NMT did not review him again until 01/21/09. It was reported at that time that he had another episode of aspiration pneumonia the end of November and was discharged to MSSLC with a 2.5 pound weight loss, though his weight was reported to be within an acceptable range (BMI was 22.6). His risk level was decreased to Level 2 and he was scheduled for review again in two months. It was of concern that Individual #216 was not reviewed in a timely manner based on MSSLC policy and generally accepted practices. Clearly Individual #216's status had not been stable for sufficient time to warrant a decrease in his risk level and would warrant ongoing review. • Individual #411 was reviewed as follows: ○ 03/03/09: He was reviewed following a swallow study with findings of swallow "within functional limits." He was below his recommended weight range. The NMT did not assign a risk level and recommended follow up on an "as needed basis." ○ 04/02/09: He was reviewed following a choking event on 03/10/09, over one month after the incident. The meeting minutes in April recommended review after another swallow study. He was noted to lose a lot of food at meals. His risk level was considered to be HIGH due to the choking incident and occurrence of pneumonia in February 2009. ○ 07/28/09: There was no evidence of further review by the NMT until July for follow up of pneumonia and PEG tube placement, three months later. He was assigned a Risk Level 1 with follow up recommended in one month. ○ 08/13/09: Status at that time included occasional high residuals, history of upper respiratory infections, aspiration pneumonia, discontinued programming due to feeding schedule, coughing, and below ideal weight range at 158 pounds with 5 pound weight loss. His Risk Level remained at 1 with follow up in one month. ○ 09/10/09: At that time he had lost another 12.8 pounds in one month, occurrence of pneumonia with hospitalization (the second since August), and repeated problems with the PEG. No changes in his plan were recommended. At Risk Level 1, he was to be reviewed again in one month.	

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		○ 10/22/09: Individual #216 had gained 12 pounds and had improved tolerance for tube feedings though he "constantly asked for food." A repeat swallow study was planned to evaluate for return to oral intake with follow up in one month. ○ 11/12/09: A repeat swallow study again confirmed severe dysphagia and he was deemed "unable to tolerate any oral feedings." His risk level was changed from 1 to 2 with follow up in three months. There was no plan to provide increased intensity of monitoring during that time with the exception of continued weekly weights. Most of those with a Level 2 designation (62%) were scheduled for annual review, 1% for review in one month, 16% for review in two months, 13% for review in three months, 1% for review in four months, 5% for review in six months, 2% for review on an as needed basis, and 2% at some other interval, such as "after colonoscopy." It was not possible to confirm that those recommended for annual review were actually reviewed on schedule, however, a sample was reviewed and showed inconsistency in follow-up per policy and accepted practice. There was no follow-up in some cases or significantly delayed follow-up in others as the following examples demonstrate: • Individual #243 was to be reviewed in July per recommendation on 05/28/09 for follow up after swallow study and Stage II decubitus ulcer. OT was to conduct pressure mapping to identify pressure areas from his seating system. There was no evidence of NMT review that month. There was no evidence of pressure mapping conducted by OT per the Positioning Wheelchair Data Base dated 03/04/10. • Individual #216 was to be reviewed in July per recommendation on 05/28/09. He was diagnosed with moderate to severe dysphagia based on MBS findings on 05/08/09. He was to get a CT scan of his lungs with medication review for possible swallowing complications from psychotropics. Speech was to conduct a trial of oral motor interventions and lemon ice. There was no evidence of NMT review that month. • Individual #239 was to be reviewed in June per recommendation on 05/28/09. The minutes documented review that month with subsequent follow up for decubitus ulcer scheduled in three months (September). This did not occur until 11/12/09. NMT minutes on 05/28/09 indicated that he had chronic wounds on his hip and ischium for more than 12 months. • Individual #97 was to be reviewed in August to follow up on her weight after calorie reduction per recommendation on 05/28/09. There was no evidence of NMT review that month. • Individual #111 was to be reviewed in November per recommendation on 08/13/09. She had PEG tube placement the previous month. There was no	

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		evidence of NMT review that month. • Individual #375 was to be reviewed in November per recommendation on 08/13/09. He had experienced aspiration pneumonia the previous month and had ongoing issues with skin integrity at tube site. There was no evidence of NMT review that month. • Individual #467 was to be reviewed in November related to mild to moderate dysphagia, diet order change including nectar thick liquids by spoon and order for GI consult per recommendation on 08/13/09. There was no evidence of NMT review that month. There were a number of individuals rated as Level 2 or 3 with significant PNM health risk concerns and inadequate follow up by the NMT in a timely manner. Some examples included: • Individual #41 had experienced multiple choking incidents in the last year. He was reviewed by the NMT on 09/10/09 and 01/21/10, yet he was assigned a Risk Level 2 and annual reviews. • Individual #161 was reviewed for a choking event (date not recorded) on 12/15/09. Her diet was downgraded to ground with nectar-thick liquids. She was assigned a Risk Level 2 with annual follow-up only. • Individual #431 was reviewed by the NMT on 03/03/09 following a choking event one month earlier on 02/02/09. She was scheduled for annual review only by the NMT due to a diagnosis of GERD. The NMT did not recognize a need to follow her closely due to the choking event. She was reviewed on 10/22/09 for another choking event (09/23/09). She was prescribed nectar-thickened liquids via spoon, assigned a Risk Level 2 and scheduled for annual follow-up only by the NMT. It was of concern that even after two choking incidents, she was considered to be a medium risk and warranted annual review only. • Individual #509 was reviewed for a choking event (August 2009) on 10/22/09. She choked on medication. She was assigned a Risk Level 2 and scheduled for annual follow-up only by the NMT. • Individual #212 experienced another choking event (date not recorded) and was reviewed by the NMT on. He was assigned a Risk Level 3 with follow up only "as needed". • Individual #75 experienced a choking incident on 10/15/09. His diet texture was reduced from regular to chopped with ground meat, with follow up in three months. He was assigned a Risk Level 2. He was reviewed on 01/21/10 with a reported weight loss of eight pounds since August. This was a 7% loss (BMI 17.7, underweight), yet he remained at Risk Level 2 and recommended for review in three months. • Individual #256 experienced a choking event on 09/09/09. His weight at that time was 106 pounds with a weight loss of 12 pounds since April (BMI 20). He	

#	Provision	Assessment of Status	Compliance
		experienced frequent belching and was to be observed during meals by the SLP. He was assigned a Risk Level 1 with follow up in one month. He was reviewed on 10/22/09 after a swallow study. He aspirated with nectar thick liquids via cup. His Seroquel was decreased because of potential side effects (belching). His plan was for honey-thick liquids and staff assistance to offer ice chips after every third bite. His risk level was decreased from 1 to 2 with annual follow up only. It was of great concern that the NMT dismissed this individual so quickly in spite of significant PNM health risks including aspiration, choking, and weight loss. Close and frequent monitoring of his status over time was seriously warranted. Observations conducted by the monitoring team found that implementation of dining plans across a number of homes was insufficient to ensure safety for all those with choking and/or aspiration concerns, particularly with regard to position, alignment, and support, as well as food texture, liquids consistency, adaptive equipment, and assistance strategies. It was of concern that these issues had not been identified and addressed appropriately. The monitoring team also observed numerous instances of inadequate alignment and support during meals and other times during the day. Some examples were: • Individual #35, Individual #521, Individual #513, Individual #77, Individual #475, Individual #544, Individual #356, Individual #405, Individual #239, Individual #378, Individual #471, and Individual #28. Inadequate trunk alignment and support, foot support, and/or head alignment was noted for each of these individuals. It was noted that staff left the transfer slings under some individuals and there were no instructions in the PNMP regarding this. The monitoring team observed numerous instances of incorrect food texture or liquid consistency offered to individual and/or other concerns inconsistent with the dining plan. The Habilitation Director accompanied the monitoring team to the many homes observed during meals. It was of great concern that there were so many errors during mealtime placing these individuals at risk of harm from aspiration or choking. Some of these examples included: • Individual #112 was served very thin, soupy cereal that was actually thinner than her beverage, which was to be honey-thick. When asked, staff indicated that they thought the cereal was appropriately thick. When asked why she was served honey-thick liquids, the staff responded that Individual #112 could aspirate and choke. • Individual #244 was also served cereal that was too thin.	

#	Provision	Assessment of Status	Compliance
		• Individual #432 was offered multiple swallows of liquid without a break. • Individuals on a chopped diet were served vegetables (zucchini and green beans) that were significantly larger than half-inch in a variety of homes. • Individual #394 did not have a dining plan. He was noted to take large bites at a fast rate and he did not have a straw opened and in his beverage. He was not supervised during the meal. • Individual #409 was drinking from a full glass though his dining plan prescribed that it be half full. • Individual #164 was noted to finish his meal in less than 10 minutes. He had experienced a choking event on 02/18/10. • Individual #319 was eating using a weighted spoon though it was not prescribed on his dining plan. By report, staff had implemented this change before the dining plan was revised and staff training was completed. • Individual #471 was to be served honey-thick liquids. The beverage he was drinking was incorrect. He was also served ice cream, which was not thickened. Individual #471 was note to cough throughout. While there were numerous others, the monitoring team discontinued recording all of the many errors in order to interact with professional staff regarding these concerns. <u>Process includes level of risk based upon physical and nutritional history, current status and includes specific criteria for guiding placement of individuals in specific risk levels</u>. The NMC Risk Assessment tool was utilized consistently during the NMT meetings for those with upcoming annual PSP meetings. As described above, the risk level designation was not always consistent with the specific health risk concerns identified by the NMT and follow-up was inconsistent with MSSLC policy and generally accepted practices. <u>Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team</u>. All PNM-related assessments were completed per the annual staffing schedule rather than based on increased risk level. Interim assessments were conducted for some individuals based on referral. There was no evidence, however, that the assessment was comprehensive, that is, that it involved other team members. The Health Status Review Committee met monthly to review all individuals living at MSSLC and assigned the following risk levels in 18 domains: **High Risk (Level 1)**: This rating typically applies to an acute or unstable condition that requires timely collaboration and increased intensity of intervention to achieve an optimal health outcome. A	

#	Provision	Assessment of Status	Compliance
		physician can determine that any condition is High Risk at any time without collaboration from the HST. Individuals discharged from the hospital should have their risk level reviewed by the physician. Once a High Risk condition is identified, the PST will meet within 5 working days to formulate a plan. The plan will be implemented within 14 days. The PST will meet at least every 30 days to monitor the effectiveness of the plan of care until the individual's condition is stabilized and the risk level is reduced. **Medium Risk (Level 2)**: This rating typically applies to ongoing conditions that are stable but require active monitoring to insure optimal health outcomes. This level also applies to conditions that may normally be considered high risk but have appropriate supports in place that have rendered the condition stable over time. Individuals at Medium Risk are reviewed and monitored by appropriate members of the PST at intervals between 30 and 180 days. The PCP or members of the PST will determine how often the PST will meet to monitor the effectiveness of the plan of care. **Low Risk (Level 3)**: This rating typically applies to conditions that are stable and require minimal or no active treatment. Individuals at Low Risk are monitored by appropriate members of the PST at intervals greater than 180 days but at least annually unless there is a change in the health condition and risk rating. These ratings did not correlate with the NMC screening in any way. In fact, these ratings were grossly inconsistent with actual facts regarding many individuals with PNM risks. For example, there were no individuals identified at high risk for choking and only 16 were assigned medium risk, yet there had been at least nine choking incidents since March 2009. For example, Individual #41 had experienced multiple incidents during that time. Three of these individuals were rated at low risk including Individual #161, Individual #509, and Individual #75. Only Individual #390, Individual #216, Individual #511, and Individual #405 were considered to be at high risk of aspiration. Only 14 others were listed at medium risk. No one was considered to be at high risk for skin breakdown, yet there were nearly 30 individuals listed with one or more decubitus ulcers some of which were Stage II and III. Per the NMT minutes, Individual #239 had serious wounds requiring treatment for over 12 months yet was listed at LOW risk for skin breakdown/decubitus ulcers according to Health Risk Assessment Tool. No one was considered to be at high risk for osteopenia/osteoporosis, yet nearly 60 individuals had a diagnosis of osteoporosis, and three had a diagnosis of osteopenia. All comprehensive assessments are conducted by the PNM Team, identify the causes of such problems, and contain proper analysis of findings and measureable, functional outcomes. Assessments were generally not conducted outside of the annual staffing schedule. Annual assessments included baseline and update evaluations with extensive documentation of facts, but with little analysis conducted and no measureable outcomes generated. See section P below.	

#	Provision	Assessment of Status	Compliance
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.	All individuals identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP). There was a plan for each individual living at MSSLC to have a PNMP and a dining plan. The format was generally consistent. As appropriate, PNMP consists of interventions /recommendations regarding: a. Positioning/alignment; b. Oral intake strategies for mealtime, snacks, medication administration, and oral hygiene; c. Food/Fluid texture; Adaptive equipment; d. Transfers; e. Bathing; f. Personal care; g. In-bed positioning/alignment; h. General positioning (i.e., wheelchair, alternate positioning); i. Communication; and j. Behavioral concerns related to intake. The format for PNMPs included supports and strategies related to assistive equipment, communication, mobility, transfers, movement techniques, positioning (seating, bed), skin care, bathing/toileting, dining equipment, and mealtime instructions. Pictures of adaptive mealtime equipment were to be integrated in the Dining Plan as well as a picture of the individual in his or her mealtime position. An additional picture showed the individual in his or her seating system/wheelchair as indicated. Each individual had a PNMP. Each had dates for implementation and update or revision, though this often referred to "annual PDP meeting" without a specific date documented. All the PNMPs appeared to be current. In most cases it was difficult to identify if changes had been made to the plan. It was noted in a number of instances that pictures were not always available. Also there were references made to instructional plans that were also not always available. Individuals who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above. All individuals who received enteral nutrition had PNMPs, even if they were NPO, receiving all their hydration and nutrition via enteral tube. PNMPs are developed with input from the IDT, home staff, medical and nursing staff and the physical and nutritional management team. The PNMPs were developed during the PNMP clinic without significant input from team members other than the OT, PT, and SLP. By report, the PST discussed the plan and made recommendations for changes as indicated. This was not evident in the PSP documents. During the NMT meeting, PNMPs were reviewed for individuals. A review of diet orders, current weight, and a brief health status review was conducted. Recommendations were made to the PST as indicated, the Nutritional Management Screening Tool was completed, and a risk level designation was assigned and documented. PNMPs are reviewed annually at the PSP meeting, and updated as needed. See above.	

#	Provision	Assessment of Status	Compliance
		PNMPS are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results. Clinicians appeared to routinely modify the PNMP as indicated by a change in status. There was little evidence that PNMP monitoring triggered any changes in the PNMPs or staff training, as the prevalence of errors in implementation was significant. There is congruency between strategies/interventions/recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. There was generally congruency between what the therapy clinicians recommended in the annual update or interim updates.	
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.	Staff implements interventions and recommendations outlined in the PNMP and or Dining Plan. As cited above, there were a large number of errors related to staff implementation of the PNMP and dining plan. In some cases, staff appeared to know what was supposed to be provided, but did not use the correct strategies. In other cases, staff did not appear to understand the significance of these errors. Individuals are in proper alignment and position. As cited above, a number of individuals were noted by the monitoring team to be in improper alignment. Plans are properly implemented across all activities that are likely to provoke swallowing difficulties and/or increased risk of aspiration. The intent of the PNMPs and dining plans was that they be followed across all settings. Implementation errors were noted in dining rooms, living areas, and day program areas. Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP. In some cases, when errors were identified by the monitoring team with regard to diet texture, staff were able to verbalize the correct diet texture and rationale. It was of concern, however, that they had not advocated making the correction before serving it to the individual. Several staff were noted to change what they were doing to correct implementation while being observed. It was of concern that these staff appeared to know what they were supposed to do, but had chosen to do something different other than that prescribed in the plan. In other cases, staff believed that they were offering the diet in an acceptable way. It was very disturbing that no one had previously identified an issue related to service of vegetables to those on a chopped diet. The rationale was that they were cooked soft enough that the size was not an issue. However, the guidelines indicated that chopped foods should be half-inch in size. Sliced zucchini was noted to be at least one and one-half inches round and green beans were at least one inch in size. Staff did not cut these or	

#	Provision	Assessment of Status	Compliance
		chop them any further before serving them. A meeting with the dietitians, food service directors and managers, and therapy clinicians was held during the on-site tour to discuss resolution of this serious issue.	
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.	Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff. Foundational training was provided to new employees in the area of physical nutritional management. This training addressed mealtime supports (less than two hours) as well as lifting and transfers (three hours). The only portion of the training that required return demonstration for competency was related to body mechanics and transfers. Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/posttest, which may also include return demonstration as applicable. By report, skills-based competency check offs were limited to transfers only. Other competencies were practiced in some cases as in thickening liquids, but check-off of specific skills was not conducted in other areas of PNM supports. Testing in those areas consisted of a multiple-choice test. All foundational trainings are updated annually. Per the documentation submitted, annual re-training for physical management was conducted every two years. Other PNM training was not updated annually at the time of this review per his report. Staff are provided person-specific training of the PNMP by the appropriate trained personnel. Habilitation Therapies staff reportedly provided competency-based training for home supervisors and these managers were then responsible to train their staff. Documentation of the home managers' training was maintained by the therapy department, and sign-in sheets for inservices provided to direct care professionals was maintained by the home. Staff training provided was not necessarily competency-based. Sign-in sheets were not requested for this baseline review, so validation of this process will be necessary in subsequent reviews. PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff that have successfully completed competency-based training specific to the individual. Clinical staff provided inservice training to supervisors/managers. At that time, the supervisor was responsible to complete the training for his or her staff. There was no consistent method used to provide PNM-related training and no consistent method to document that specific competencies were achieved. The type, frequency, or intensity of training did not vary dependent on PNM risk levels. Staff are trained prior to working with individuals and retrained as changes occur with the PNMP. Same as above.	

#	Provision	Assessment of Status	Compliance
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.	A system is in place that monitors staff implementation of the PNMPs. On a regular basis (at least monthly), all staff will be monitored for their continued competence in implementing the PNMPs. Extensive PNMP monitoring was conducted by 13 PNMP Coordinators. These staff were previously direct support staff and the PNMP Director and COTA were responsible for supervision and training of these staff. None of the completed forms, however, identified the staff providing supports to the individual monitored. The current plan for monitoring did not systematically ensure that staff were monitored to validate continued competency. In the event that issues were identified from the monitoring, it was reported that the monitors conducted coaching and inservice training. Additionally, approximately 100 Meal Observation Sheets were completed by the PNMP Coordinators staff during the first quarter of 2010. These sheets were not person-specific, but reviewed all individuals in the dining area at that time. Again, no staff were identified who were observed during this monitoring. Copies were returned to the PNMP Director. By report, she contacted the appropriate staff when corrections were indicated. Monitoring was conducted across breakfast (22%), lunch (32%), and dinner (31%), and 13% had no meal designated. One completed observation designated both breakfast and lunch on the same form and two others did not designate a meal. A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. MSSLC did not submit a policy that specifically addressed the monitoring process. Policy #012 Physical Nutritional Management, approved on 12/17/09 with implementation on 01/31/10, was reviewed. It included a section on PNM monitoring which outlined the following: • PNMPs should be monitored as scheduled and as needed by residential supervisors, nursing, therapy, and other professional staff to assess effectiveness of plans and to make changes as indicated; • Supervisors should report problems and training needs; • Professional staff should monitor for proper use of equipment and intervention strategies; ensure proper implementation and to correct problems; • Individuals with identified PNM issues should be monitored regularly by NMT; • Daily monitoring of cleanliness, wear and need for repair by direct support staff; and • Monitoring of equipment at least annually and as needed by therapy staff. There was no policy that outlined frequency or distribution of monitoring based on PNM risk level or any other designation. There were no plans to routinely validate monitors to	

#	Provision	Assessment of Status	Compliance
		ensure consistency and accuracy, though this was discussed at length with Margaret Farrington, OTR, and PNM Director. Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). At the time of this on-site review, the PNMP coordinators were assigned caseloads in order to cover all homes. The primary focus of the PNMP tool addressed positioning and transfers, accuracy and availability of the plan itself, and the use and condition of all equipment. Correct use, condition, and cleanliness of equipment were reviewed using the tool, but effectiveness was not. Focus on positioning was limited. It was not apparent that observational monitoring of bedtime and bathing positions were done routinely. In many cases, the answer was always that implementation was acceptable. In some, the form was marked "partial," but there were no comments so as to know what the concerns were with implementation on that date. There were many elements marked "N/A" indicating that the indicator was not observed. Again these were not person-specific and the forms rarely cited an issue with a specific individual. All members of the PNM team conduct monitoring. At the time of this review, the PNMP Coordinators had conducted formal PNM monitoring. Other clinical staff reported routine monitoring on an informal basis, but there was no documentation of this. Other MSSLC professional staff and supervisors were to conduct monitoring, though this system was not yet in place. As stated above, mealtime observation was conducted by all OTs and all SLPs. PT was not involved in formal monitoring of PNMPs or meal observations at the time of this on-site review. Discipline-specific review and assessment was conducted by the RN and RD team members but there was no evidence that they participated in the formal review of PNMPs or dining plans. Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team. The PNM team identified trends, and addresses such trends, for example, to enhance and focus the training agenda. There was no trend analysis of PNMP monitoring or mealtime observations at the time of this on-site review. Plans to do this had not been developed. Nevertheless, the monitoring team observed individuals eating in improper alignment or with incorrect support during the on-site review. Diet texture or liquid consistency errors were also noted. Even so, very limited diet texture, position/alignment, or transfer compliance errors were documented by the MSSLC monitors from January through March 2010. Validity of this system and of the monitors was of concern. This will be a critical element to address regarding training of the new PNMP monitors. Immediate intervention is provided if the person is determined to be at risk of harm.	

#	Provision	Assessment of Status	Compliance
		There was recurrent evidence of intervention at the time of this on-site tour by the Habilitation Therapies Director who accompanied the monitoring team during observations throughout the week. In addition, issues identified were reported to their supervisor who was to follow up on these issues. There was no system to track this or to follow concerns through to resolution. There was no mechanism to aggregate the data gathered through the monitoring process for use to focus training needs. Other deficiencies noted during monitoring are corrected within an appropriate period of time based on the level of risk that they pose. There was no system to track this or to follow concerns through to resolution. There was no mechanism to aggregate the data gathered through the monitoring process for use to focus training needs. System exists through which results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor. By report, supervisors were notified of issues identified via monitoring. There was, however, no consistent method of documentation to this effect. There were no reports generated to track system change or system improvement on a routine basis. Process includes intermittent internal validation checks to ensure accuracy. No validation checks were conducted at MSSLC at the time of this review by report or documentary evidence submitted.	
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.	A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. NMT meetings were held monthly to review individuals with regard to aspiration pneumonia, MBS studies, choking (evidence of nine events since March 2009), significant weight loss, PNMP/PSP reviews, and follow ups from previous meetings. The approach utilized included a review of previous PNM history and discussion to identify potential recommendations. Follow up was generally consistent, but there were some significant oversights. Actual trend analysis on a person-specific and/or systemic basis was extremely limited. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators. PNMP monitoring was conducted using the PNMP Monitoring Form and focused predominately on staff compliance with implementation of the PNMP, though specific staff were not identified. Monitoring was not person specific and the frequency of monitoring was not driven in any way by need or risk level. Additional person-specific monitoring by clinicians was generally in response to a request, referral, or identification of a problem rather than scheduled routine monitoring of health status and the effectiveness of supports to address identified PNM health risk	

#	Provision	Assessment of Status	Compliance
		indicators. There was no mechanism in place to tabulate findings from follow up monitoring for trend analysis per individual or system wide. <u>Issues noted during monitoring are followed by the PNM team and will remain open until all issues have been resolved and appropriate trainings conducted</u>. There was no evidence that the NMT reviewed the findings of PNMP monitoring or mealtime observations to ensure resolution of any identified concerns. <u>The individual's PNM status is reviewed annually at the PSP, and all PNMPs are updated as needed</u>. Annual updates were completed by OT/PT and SLPs on an annual basis. A summary of findings from those reports was included in the PSP. There was generally discussion of the PNMP in the OT/PT/SLP sections of the PSP with recommendations to continue, but recommendations for changes to the PNMP were not consistently summarized. An annual "Feeding Evaluation" was completed for each individual at MSSLC by report. None of these was submitted so they were not reviewed during this baseline site visit. <u>On at least a monthly basis or more often as needed, the individual's PNM status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results</u>. There was no evidence in the records submitted of routine monthly review by the PST or member(s) of the NMT. Quarterly reviews were generally related to availability of equipment only. <u>Members of the PNM team complete monitoring system</u>. There was no evidence of formal meal observations or PNMP monitoring conducted by all clinical staff. <u>Immediate interventions are provided when the individual is determined to be at an increased risk of harm</u>. Limited concerns were identified related to improper implementation of plans related to diet texture, dining plan instructions, and position and alignment in the monitoring tools submitted, though a number of these were identified based on the observations of the monitoring team and described above. Most issues identified via facility monitoring were related to missing equipment or the need for repairs. It was of concern, however, that this system appeared to be ineffective in ensuring staff compliance, competency, and individual safety, such as the issue with cooked vegetables as described above. When errors were pointed out by the monitoring team, the staff generally responded quickly to remedy the concern.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status</u>. There were approximately 58 individuals who received enteral nutrition. A number of individuals	

#	Provision	Assessment of Status	Compliance
	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.	were scheduled for annual review by the NMT, but the discussion generally did not address whether enteral nutrition continued to be medically necessary. There did not appear to be a specific discussion of this issue during the PSP annual meeting with other PST members. The need for continued enteral nutrition is integrated into the PSP. Issues related to enteral nutrition were evident throughout the PSP with regard to diet order, nutritional assessment, and other medically-related information. There was no evidence that the PST addressed the continued need for enteral nutrition. When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used. There were some cases when there was documentation of discussion regarding potential for return to oral intake, for example, Individual #411. There is evidence of discussion by the PST regarding continued need for enteral nutrition. There was insufficient evidence, however, that the PST discussed the individual's condition and that enteral nutrition continued to be medically necessary. A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT). State policy did not clearly define the depth of assessment required. There did not appear to be a standard for how these assessments were to be completed and there did not appear to be collaboration across disciplines. Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. Via PNMP/dining plans, there were strategies designed to address diet texture, liquids consistency, position and alignment, and assistance techniques. As described throughout this review, however, there were numerous examples of inadequate implementation of these plans by staff. The current system of monitoring was ineffective in the identification and remediation of these errors and this put individuals at risk of harm for aspiration and/or choking and increased the potential for tube placement.	

Recommendations:

1. Include PT staff in NMT meetings; consider closer collaboration with the Health Risk Screening process as well.

2. Ensure increased opportunities for annual continuing education opportunities to include all NMT team members.

3. It appeared that the Chairperson of the NMT was assigned to a COTA because there were insufficient other clinical staff to fill this role. MSSLC

should carefully assess the ramifications of this given that a COTA was not qualified to conduct assessments or develop treatment plans.

4. Establish measurable outcomes and thresholds related to occurrences of risk indicators or identified PNM concerns.

5. Provide a more thorough analysis of objective data to drive a comprehensive approach to interventions. Ensure that consideration is given to assessment of potentials and functional skill acquisition as described in OT/PT and Communication sections below.

6. Utilize the monitoring system to fine tune PNMPs and dining plans for consistency and accuracy and to ensure improved staff compliance with proper implementation. Trend analysis of the findings of this monitoring should be utilized to better target staff training.

7. Revise current new employee training to ensure that it addresses skills-based competencies rather than only knowledge-based learning objectives. Competency check-offs should include an activity analysis, highlighting the skills necessary to complete the task. Staff should be expected to perform each skill to criteria to achieve competency. Create annual refresher courses with competency-based check-offs to ensure continued competence.

8. All individual-specific training must be competency-based and documented with staff sign-in sheets. Only staff who have been checked off should work with those at highest risk. The current system that trained only one staff, the home manager, was clearly ineffective and the competence of direct support staff for implementation was seriously deficient.

9. Ensure that the PNMP Coordinators receive adequate and appropriate competency-based training, routine review and oversight of the monitoring process in action, and revalidation of competency on a routine basis to promote improved consistency and accuracy. At this time, the process was merely a paper exercise and provided little to ensure that individuals were protected from risk of harm.

10. Ensure that the monitoring system is based on individual-specific needs; those at higher risk should be monitored with greater frequency.

11. Consider revision of monitoring tool to better assess staff performance of basic skills. Findings should drive staff training plans. A mechanism to ensure that staff performance related to implementation of PNMPs is systematically evaluated will be critical to ensure continued competency.

12. Conduct trend analysis of all monitoring data. Review findings and make system adjustments.

13. Review the existing systems of risk assessment to ensure greater integration. Risk levels should be determined by potential risk of harm. Implementation of supports and services to minimize risk do not automatically reduce the individual's potential for risk of harm. The interventions must be effectively in place long enough to attain and maintain stable risk status for a prescribed length of time before risk level is downgraded.

14. PNM review should focus on PNM concerns with follow up through to problem resolution. Set outcome measures with regard to specific risk indicators and timeframes for achievement. For example, Mary will be pneumonia free for six months. Interventions should support achievement of identified outcomes. The NMT should continue to monitor until the individual attains and maintains at the goal level.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Occupational/Physical Therapy Services #014P, 11/04/09 o Current Census Alpha o CVs for PNMT members o Continuing Education Records for PNMT members o PNM Clinic assessment worksheet o Wheelchair/Related Equipment Work order form o Occupational Therapy Functional Eating Skills Assessment worksheet o Occupational Therapy Baseline Evaluation worksheet o Habilitation Therapy Services, dated 02/22/10 o Habilitation Therapy Services Database, 02/19/10 o Positioning Wheelchair Data Base, 03/04/10 o List of Individuals with Other Ambulation Devices o List of Individuals with Orthotics and/or Braces o List of Individuals Who Used Wheelchairs as Primary Mobility o List of Individuals with Transport Wheelchairs o OT/PT Evaluations for the following: • Individual #231, Individual #165, Individual #451, Individual #494, Individual #401, Individual #438, Individual #6, Individual #352, Individual #227, and Individual #454 o OT/PT Evaluations, worksheets and documentation related to wheelchairs for the following: • Individual #177, Individual #494, Individual #231, Individual #451, and Individual #401 o PNMP format o Completed PNMPs submitted o Dining Plan format o Departmental audits dated 08/25/09 and 01/06/10 by Margaret Farrington, PNM Director o Occupational/Physical Therapy Services #014P, 11/04/09 o Audit of OT/PT Baseline Evaluations of New Admissions by Margaret Farrington, dated 03/22/10 o Staff New Employee training curriculum Functional Eating Skills, Functional Dining Skills, Lifting, and Occupational Therapy Pre-service Training o Meal Observation Sheets o Sample positioning plan for • Individual #511 o List of individuals who had experienced a falling incident during the past three months o Personal Record documents including: Personal Support Plans and addendums, Annual Medical Summaries, Nursing Annual and Quarterly Assessments for the last year, QMRP monthly reviews for last 12 months, NMT reports and screenings, Health Risk Assessment Tool, OT/PT Assessments and

	treatment notes, OT/PT Assessments/Updates and treatment notes (only assessment for Individual #405, dated 03/02/10, was submitted), OT/PT/SLP Consults, Modified Barium Swallow Study reports for the following individuals: • Individual #544, Individual #513, Individual #560, Individual #511, Individual #501, Individual #488, Individual #481, Individual #47, Individual #438, Individual #390, Individual #216, Individual #40 Individual #30, Individual #411, Individual #397, Individual #119, Individual #588, Individual #375, Individual #439, and Individual #77 Interviews and Meetings Held: o Coleen Range, MA, CCC-A, director o Anita Lane M.Ed., OTR o Doris Ricketts, MBA, OTR o Sandra Opersteny, PT o Sandy Leggett, PT o Discussions with various supervisors and direct care professionals o Discussions with various day program staff Observations Conducted: o Mealtimes o Living areas and day program areas
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The occupational and physical therapists employed or contracted at MSSLC had many years of experience as clinicians, many of which were with individuals with developmental disabilities. They demonstrated interest in the achievement of the elements required by the Settlement Agreement, but the current systems would likely make that difficult. There were insufficient staff to ensure that all individuals received appropriate and timely supports and services. All or most of the clinicians participated in annual assessments in the PNMP clinic, however, this did not appear to be a time and cost effective manner in which to accomplish this. There was evidence of a lag in the implementation of needed services and delays in completion of assessments. Of great concern was the inadequate implementation of PNMPs, particularly related to mealtimes and positioning. The existing system of monitoring was ineffective in generating appropriate changes in staff compliance and individual health outcomes. The PNMP Coordinators were inadequately trained and supervised. There was no system to track findings and identify trends to guide further supports and training to direct care professionals responsible for implementing critical physical and nutritional management supports.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	<u>The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience</u>. The census at MSSLC was approximately 450 at the time of this baseline review. The department director, Coleen Range, MA, CCC-A, was an audiologist. There were three physical therapists, though only one was full time, Sandra Opersteny. The other two were contracted for 30 hours a week (Sandy Leggett), and one day a week for 9-10 hours only (Arthur Norton). There were two physical therapy assistants, Betty Cotton and Cynthia Buckmeyer. Primary PT responsibilities were for new admission evaluations, PNM clinic with OT, wheelchair, assistive devices and mobility issues. It was reported that they had been directed to refer out for some acute care concerns such as sports injuries. OT services were provided by two full-time occupational therapists, Anita Lane, M.Ed. and Doris Rickets, MBA, OTR, and three OT assistants, Victoria Lee, Karen Fleming, and Lisa Finley. No evidence of licensure was submitted for any of the therapy staff. There was one therapy technician. OT was responsible for "feeding evaluations" and the provision of wheelchairs, in addition to new admission evaluations and PNM clinic assessments with PT. By report, direct OT was provided for four individuals related to a stroke and to contracture management. Given the census of 450 at the time of this on-site review, average caseloads for each OTR included approximately 225 individuals. One of the COTAs worked in the wheelchair shop and the other was responsible for the NMT, so only one COTA was available for possible OT supports and services for 425 individuals. There were no vacant OT positions, by report. Average caseloads for two of the physical therapists included approximately 225 individuals because the PT who worked one day a week was assigned to address more acute issues, such as fractures and sports injuries. These were ongoing needs due to the mobility of many of the individuals admitted to MSSLC. Fabrication of seating systems occurred on site. Fabricators were responsible for collaborating with therapy clinicians to design seating systems for individuals living at MSSLC, fabricating custom components, and completing repairs and modifications. At the time of this review, there was a shop foreman with three additional orthotics technicians, though one was to retire at the end of the month. <u>All individuals have received an OT and PT screening. If newly admitted, this occurred within 30 days of admission</u>. Screenings were not conducted, but instead, full OT/PT assessments for those newly admitted to the facility were provided, by report. These assessments were integrated assessments completed by at least one physical therapist and occupational therapist and signed by both. A PNM Evaluation Worksheet was	

#	Provision	Assessment of Status	Compliance
		submitted for Individual #498 as requested by the monitoring team after observation of the OT/PT clinic held on 03/23/10. An additional worksheet was submitted for Individual #480, dated 01/26/10. Ten OT/PT assessments were submitted to represent those completed by each clinician, as requested. Since these were integrated assessments, it appeared that those including all clinicians were selected for submission. It was noted that, based on record review for an additional 20 individuals, an OT/PT evaluation was submitted for each with the exception of Individual #47, however, there was reference to an OT/PT assessment in her PSP, dated 10/30/09. Most of these were current within the last 12 months with the exception of Individual #488, Individual #216, and Individual #501. Each of these was dated in February 2009 and the PSPs had occurred in April of that year, so an annual meeting had not likely been held as yet for 2010. Of the assessments submitted and reviewed, approximately half were updates and half were baseline evaluations. While each was of a similar format, some addressed the sections more comprehensively than others and it was more difficult to locate specific subheadings within the report with some formats used. Though this element was not specifically evaluated for new admissions during this baseline review by the monitoring team, an internal audit conducted on 03/22/10 suggested that some assessments were delinquent or not present in the individual records including Individual #363, Individual #235, Individual #262, Individual #463, Individual #197, Individual #163, Individual #388, Individual #585, and Individual #117, each of whom were new admissions. This will be investigated further in subsequent monitoring team reviews. All individuals identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification. Many individuals living at MSSLC received some level of indirect OT/PT supports and services, such as adaptive equipment or a dining plan. Staff reported that it was a "long standing law" that all plans were developed and implemented within the 30-day time frame. There were very few individuals who received direct supports. While it was not possible to effectively evaluate this element during the baseline review, further investigation of this will be conducted in subsequent reviews. It was noted, however, from consultation reports and progress notes that there was a significant lag in services for Individual #481 related to a referral to "rule-out pressure to buttocks," dated 09/18/08. The consult was documented on 06/17/09 when she was seen for pressure mapping in her "new wheelchair." She reportedly had been issued a new wheelchair on an emergency basis due to falls and pressure areas to her buttocks. The pressure mapping revealed mild pressure areas at the coccyx with her cushion, then she was reassessed on a Roho cushion with no pressure areas identified. She was issued	

#	Provision	Assessment of Status	Compliance
		a Roho cushion on that date, though nearly nine months after the initial request. Individual #588 had been referred for assessment of wheelchair footrests on 10/13/09 following the fracture of her right leg at the ankle. The consult was completed on that date. By report, she had a normal bone scan in 2005 and the PT determined that she did not have sufficient strength to kick the footplate to result in this particular fracture. The consult stated that "this type of injury is more commonly referred to therapy when a person stands with their foot bent at the ankle with their own weight causing the injury." It was of concern that further assessment of position, transport, and staff adherence to safe handling and mobility strategies was not investigated by this clinician as part of the consult to rule out other potential support needs, including staff training. <u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status</u>. Though it was unclear as to how long an evaluation schedule had been in place, at the time of this review, the plan was that each individual would receive a baseline OT/PT evaluation every three years with updates completed in the interim for those that were provided some level of support. The format for the baseline and update evaluations were very similar and would be difficult to discern were it not for the title because there was generally no specific reference to a baseline evaluation with date. As a result, the updates contained a significant amount of information and did not appear to "update" the reader as to the individual's current status relative to the previous status at the time of the baseline assessment and, as such, served essentially as another baseline. The assessments were clearly more focused on impairments rather than on function and the potential for skill acquisition. Assessment detail and clinical reasoning also varied greatly from report to report. In many cases, there was insufficient baseline outlined in the assessment to use for assessing progress as a result of intervention. Neither an analysis of findings nor a rationale was provided as a foundation for the recommendations identified. In most cases, the assessments appeared to be for someone new to the clinical staff and that ongoing monitoring throughout the year with appropriate intervention at that time had not occurred. Extremely large numbers of recommendations were outlined (in some cases nearly 50 recommendations were made) and it was difficult to track back as to why each one was important. Some reports organized the recommendations according to subject; those related to transfers were listed together under a heading, and those related to the dining plan were listed together under that heading, for example. Others just listed each one out in a long list. There was significant repetition of information throughout the reports. <u>Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by</u>	

#	Provision	Assessment of Status	Compliance
		change in status or PST referral. This standard was not specifically reviewed because the sample did not include individuals who did not receive some level of therapy supports and services. For example, all individuals were to be provided a PNMP and a dining plan. Each individual who received even these indirect supports received an OT/PT assessment every three years with an annual update. By report, this was provided, but will require further examination during a subsequent monitoring team review. Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment. Per the baseline assessments/updates reviewed and lists submitted, over 140 individuals required the use of a wheelchair as their primary means of mobility. Another 46 individuals used a wheelchair for transport only. In most of the reports, there was a statement as to whether the wheelchair met that individual's transportation and positioning needs. While the annual assessment was an appropriate time to address these concerns, it should not be a substitute for routine monitoring with timely identification of concerns throughout the year and not only in preparation for the annual meeting. Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. There was no extensive review of health status or relevant consults and diagnostics in the assessments reviewed. History consisted only of a list of diagnoses. Some included a list of medications, others did not. Physical/nutritional support concerns, such as risk indicators and hospitalizations, were not consistently addressed. The following individuals were examples of those identified at "high" risk by MSSLC, yet this was not evident when reviewing their OT/PT assessments: Individual #231, Individual #397, Individual #375, Individual #30, Individual #390, Individual #439, Individual #501 and Individual #216. When reported, the information was buried in the text and specific risk indicators could not be clearly and systematically tracked throughout the report to ensure each was appropriately addressed via supports. In a few cases, it was reported that the individual had been reviewed by the NMT. For example, Individual #231 was reviewed with concerns related to GERD, obesity, and colon resection, and was considered to be at Risk Level II. This was reported twice in the same report, however, none of the recommendations were linked to, and specifically designed to, address any of his risk indicators. Issues related to the wheelchair were addressed in more than one section and it made it difficult to know where to look for specific information about the individual. As stated above, recommendations numbered nearly 50 in some cases. It was difficult to imagine that the issues identified requiring new supports and modification to existing supports had not existed for some time prior to the assessment. In that case, the system to monitor, identify, and remedy those concerns failed to ensure that individual needs were	

#	Provision	Assessment of Status	Compliance
		met in a timely manner. In one example, Individual #30 was reported to have fallen out of the bathing gurney, so clarification of the proper bathing equipment and level of staff assistance was outlined in the annual assessment. This should have been evaluated previously so changes and/or clarification could have been provided immediately after the fall. As stated above, the lengthy lists of recommendations made it difficult to track the relevance of each and to ensure that all identified concerns were addressed. While they may have been in many of the assessments, it was extremely difficult for the reader to process the information. As a result, the reports were not user familiar to any staff, but particularly to non-clinical support staff. Further, it appeared that concerns were addressed only at the time of the annual assessment rather than as issues came up and were identified through an effective, routine system of monitoring. <u>Evidence of communication and or collaboration is present in the OT/PT assessments</u>. OT and PT completed a combined assessment report. At times the SLP participated but a separate assessment report was written. The process was observed by the monitoring team on 03/23/10. Aspects of the process appeared to be effective, though there were many clinical staff in the area, but only a couple actually participating in the process. With serious challenges facing the department related to the Settlement Agreement, it did not appear to be the most effective use of professional staff time. The value of professional exchange and cross training was not evident, and little was contributed to the actual outcome for the individual evaluated. Assistance from technicians would be valuable to obtain extra equipment for positioning trials, but use of licensed clinicians was not cost and time effective. Opportunities for this kind of experience were recognized by the monitoring team, but the process should be organized, with clear expectations for participation and may be better served as a scheduled event for complex assessments or as a peer review process, but perhaps not on a routine basis for each and every assessment completed.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the	<u>Within 30 days of a comprehensive assessment, or sooner as required for health or safety, a plan has been developed as part of the PSP</u>. Plans developed were generally limited to PNMPs and dining plans. Plan development was the responsibility of habilitation staff and, in the case of PNMPs and dining plans, implementation was by direct care professionals. By report, all plans were in place and when a revision was necessary, each of the plans was modified. Revisions were documented in a variety of ways with dates in most instances, though some were noted to state "mini-staffing" or "annual PSP staffing." <u>Within 30 days of development of the plan, it was implemented</u>. Most revisions to plans required immediate implementation to address health and safety needs. Implementation	

#	Provision	Assessment of Status	Compliance
	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.	dates were not evident on the plans and this could not be confirmed. It was reported in an internal audit report, however, that in some cases, following modified barium swallow studies, changes to the PNMPs and dining plans had not been made in a timely manner. Appropriate intervention plans are: a. Integrated into the PSP; b. individualized; c. Based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies; and c. Contain objective, measurable and functional outcomes. Review of PSPs revealed that recommendations for adaptive equipment identified in the PNMP were listed in the OT/PT assessment section of the document. In addition, there were no objective, measurable, and functional outcomes with established criteria associated with direct therapy interventions. The analysis contained in the assessments identified rationale in some cases, but the structure of the assessment document itself made locating that information difficult, and it was not user friendly for other PST members. There was often no clear link to specific PNM risk indicators. Interventions are present to enhance: a. movement; b. mobility; c. range of motion; d. independence; and e. as needed to minimize regression. Interventions provided were largely in the form of supports via the PNMPs. A limited number of direct interventions were provided by OT/PT clinicians primarily for acute concerns. Most of the documentation submitted indicated that the interventions were largely focused on range of motion, with some intervention for ambulation, but this was limited. The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used. Each of the PNMPs reviewed listed specific assistive technology and equipment to address the individual's needs. In most cases, the rationale established via assessment was insufficient. Therapists provide verbal justification and functional rationale for recommended interventions. There were no activity plans submitted, but all monthly progress notes submitted had a stated purpose for the interventions provided. On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. There was no system of routine review of PNMPs for effectiveness other than annually at the time of the assessment. The monitoring system did not effectively address concerns as evidenced by the numerous errors in implementation of these plans. The system was predominately problem oriented rather than preventative in nature, and it appeared that most of the needs were identified and addressed via referrals or at the annual assessment only, rather than throughout the year. There was no current system to reflect review of the effectiveness	

#	Provision	Assessment of Status	Compliance
		of any changes that were made.	
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.	Staff implements recommendations identified by OT/PT. As described above, there were numerous instances of incorrect implementation of dining plans. In addition, staff implementation of position and alignment guidelines was inadequate, or alignment and support was insufficient for safe and optimal function. The monitoring forms submitted failed to identify improper implementation of PNMPs. See below. Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations. The only competency-based training aspect of new employee orientation provided in the area of OT and PT supports was related to lifting. Training in other areas of new employee orientation relied on written test questions and classroom participation. Person-specific training was provided to home managers and, by report, was competency-based. Home managers were then responsible for the training of staff assigned to their home. Informal coaching of staff was supposed to occur as an aspect of PNMP monitoring when concerns were noted. As described below, this was not consistent and the Coordinators were not adequately trained to competency themselves. Staff verbalizes rationale for interventions. Staff were generally not able to recognize when an individual was not in adequate alignment. This was evidenced by the number of individuals observed by the monitoring team in improper alignment during this on-site review. As such, staff clearly were not able to identify the rationale for such interventions. As described above, numerous errors were noted with regard to food texture and liquids consistency as well as mealtime adaptive equipment prescribed on the PNMPs. Staff did not re-position individuals prior to mealtime and were clearly unable to identify the importance of proper alignment for safety, to ensure adequate nutrition and hydration, and to promote independence.	
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	System exists to routinely evaluate: a. fit; b. availability; function; and c. condition of all adaptive equipment/assistive technology. By report, a COTA and other clinicians conducted regular monitoring for fit and function. There was no system to document the actual frequency of this monitoring to ensure that it occurred routinely and across all homes. It was reported to occur quarterly. In addition, staff were responsible to notify Habilitation Therapies for concerns related to adaptive equipment and assistive technology. As described below, this system was marginally effective as a number of equipment-related concerns were noted during formal PNMP monitoring. A policy/protocol addresses the monitoring process and provides clear direction	

#	Provision	Assessment of Status	Compliance
	and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	regarding its implementation and action steps to take should issues be noted. At the time of this review, policy #014 Occupational/Physical Therapy Services addressed monitoring by mandating that a system be implemented that addressed: 1. the status of individuals with identified occupational and physical therapy needs; 2. the condition, availability, and appropriateness of physical supports and assistive equipment; 3. the effectiveness of treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and 4. the implementation of programs carried out by direct support staff. There was no formal policy regarding how this monitoring system should be implemented with regard to frequency or how to follow up in the case that issues were noted during this process. On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs. The current system of monitoring did not specifically target review of staff competence. The current system was more person-specific and did not identify the staff providing supports at the time the monitoring was conducted. There was no mechanism in place to track the frequency or findings through formal review of competency for staff. For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff. All new employees attended a four hour training related to physical management as an aspect of the new employee orientation. Sign-in sheets for training of home managers were maintained by Habilitation Therapies if conducted by those staff. Additional training that was conducted by home managers was to be maintained on the home. Sign-in sheets were not requested related to transfers and lifting during this on-site baseline review, so further assessment of implementation and documentation of this system will be necessary in the future. Responses to monitoring findings are clearly documented from identification to resolution of any issues identified. There was no mechanism to document a plan of correction on the form in order to track problem resolution. There was not a clear method other than report by the Coordinators to bring a concern to their supervisor's attention via the "office monitor" who notified the OTR and COTA within that department. They were to then report this to the Habilitation Therapies Department. It was reported that this was done, but was not clearly documented or tracked. This	

#	Provision	Assessment of Status	Compliance
		process was very convoluted and, as described below, was not effective. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. The current system was primarily reactionary, with staff reporting a problem rather than a proactive system that quickly and routinely identified missing and dirty equipment as well as repair and preventative maintenance needs. The clinicians stated that "staff always call us." By report, basic wheelchair checks were conducted quarterly to identify routine maintenance and issues related to cleanliness in addition to the physical management plan monitoring conducted by the 13 PNMP Coordinators. There did not appear to be a specific schedule for this to ensure that individuals considered to be at higher risk were monitored with greater frequency. The Coordinators were assigned a caseload in which individuals were to be monitored every two weeks "through resolution of identified problems." At this time, however, there was no established tracking system to determine how consistently this schedule was implemented. Further, PNMP monitoring was to be conducted by master trainers, unit directors, assistant directors, psychology staff, and nursing case managers. When direct support staff noticed an issue, they reportedly contacted the wheelchair shop. By report, there were duplicates of adaptive mealtime equipment and in some cases the staff were able to locate a replacement when a spoon or cup was missing. The monitoring team observed cases in which the appropriate adaptive equipment was not available and there were no staff responsible for appropriately supervising the individuals to ensure their safety. Some examples, included: • Individual #394 – He was observed taking large bites with a care spoon. His dining plan indicated that he was at risk of choking. The dining plan further prescribed that he should drink all liquids from a straw, which was lying on the table next to his plate. He was to be served chopped foods with ground meat. The meat was ground but the green beans he was eating were large and had not been cut into half-inch pieces as necessary with a chopped diet. The direct support staff near this table was assigned to be one-to-one with another man at the table and when he had finished his meal, they both left the area as Individual #394 continued to eat the incorrect diet texture at a fast pace, taking large bites. He then attempted to gulp his liquids without the straw and at that time the monitoring team intervened and asked that someone provide him with the straw. This was brought to the attention of the supervisor in the dining area. On a positive note, however, the monitoring team conducted additional observation in this same home on a subsequent day. This time, Individual #394 was seated at a table with other individuals and appropriate staff were seated at the table for supervision. He was eating the appropriate diet and was using the correct adaptive equipment including the straw. This was also brought to the attention of the same supervisor.	

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		• Individual #546 - In this case the monitoring team noted that she was to use a care spoon per her dining plan, but she was using a fork much like a spoon to scoop large bites of food, including pieces of bread. When this was brought to the attention of the direct care staff present in the area, she clearly had not noticed this error and had not intervened. She indicated that she thought Individual #546 was permitted to use a fork. A supervising staff member was asked about this and she too indicated that she could use the fork as long as the care spoon was available. She pointed out that it was there on the table. During the discussion, a behavior therapist joined in who also stated that she could use the fork. She proceeded to call to ask for clarification. After several calls, she contacted the Habilitation Therapies Department and the person on the phone indicated that it was okay for her to use the fork for foods that could be eaten with a fork. This was not outlined in her dining plan and was clearly not an acceptable practice. It was later clarified that this absolutely was not permitted and staff training was to take place to make the correction. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs. It did not appear that the current system of monitoring adequately addressed issues related to the effective implementation of the PNMPs. Numerous implementation errors were noted by the monitoring team and most of the completed PNMP monitoring forms did not identify any concerns. Margaret Farrington, OTR, and Pam Harlan, a COTA were responsible for training, supervising, and monitoring the effectiveness of the 13 PNMP Coordinators. It was of serious concern that these newly assigned staff had not been adequately trained to carry out this critical responsibility and that the 1800 or so forms completed in the last quarter did not yield information of value to ensure the health and safety of those with PNM concerns. Forms submitted represented monitoring completed for the months of January through March 2010. Monitoring was completed across homes and at various times of day. It was estimated that there were at least 500 monitoring forms completed in January and February, with approximately 800 completed in March. It appeared that the majority of monitoring was conducted prior to 5 p.m. rather than a strong sample across all shifts. The monitoring team observed one PNMP Coordinator conduct monitoring in a day room area of one home. Individual #28 was observed in a posterior tilt and her thighs were extended significantly forward of the seat bottom. Her head was well below the head rest of her wheelchair. Individual #77 was noted to be leaning to the right and it was noted that she was also leaning in the picture intended to demonstrate "proper" positioning for Individual #77 in her PNMP. Individual #475 was observed in a posterior tilt with rounded shoulders, her head was forward and she was leaning on her left elbow.	

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		At first, the PNMP Coordinator indicated that she thought all the women in the room were appropriately positioned at that time. During further discussion with this staff person, it became more apparent that that there were issues related to their position. She then stated that she had noted these problems before but that she had not previously reported any concerns. Clearly, she was not trained adequately to accurately conduct the monitoring in an effective manner and to provide appropriate coaching to the direct support staff in the room. She required prompting to assist the staff to attempt to make corrections. The Coordinator stated that she had been in this position for one month. There was an apparent acceptance of poor alignment and support throughout the facility. When the PNMP was not implemented appropriately it would not effectively meet that individual's needs. There were no aggregated data in order to trend the findings of the PNMP Coordinators, however, it was apparent from the forms submitted, that finding an issue with PNMP implementation was more the exception than the rule. Observations by the monitoring team cited numerous issues related to implementation of positioning plans and dining plans. Often, even if there was a "no" answer or "partial" answer, there was no description to identify what the concern had been. If an issue was not identified clearly, the Coordinators could not provide training or coaching with significant frequency and as a result, the system would not effect change in compliance with PNMP implementation. <u>Data collection method is validated by the program's author(s)</u>. There were no interventions implemented that involved data collection. Documentation and tracking of progress was limited to progress records in SOAP format.	

Recommendations:

1. Careful analysis of OT/PT staffing is needed to ensure that all elements of the Settlement Agreement can be implemented and sustained.

2. Training of PNMP Coordinators must be competency-based to include didactic presentation of content information necessary to recognize issues related to PNM. This must include monitoring strategies, follow-up steps, documentation, and interaction with staff and supervisors as well as hands-on opportunities to complete the monitoring form and, in addition, validation by a licensed clinician to ensure accuracy and consistency. Documentation should verify successful performance of all skills-based competencies. Minimum criteria should be established and independent monitoring should not be permitted for each PNMP Coordinator until those criteria are met. Routine monitoring of the PNMP Coordinators should be conducted to validate continued competency.

3. The monitoring system must include a mechanism to ensure that issues and concerns are appropriately identified, recorded, and addressed with documentation of problem resolution. Each identified concern must be addressed via a mini-plan of correction with evidence of completion such as staff training, submission of work order, equipment replacement, and so forth.

4. All monitoring results must be tabulated for trend analysis to identify systems issues to guide training and follow up, as well as to celebrate areas of excellence.

5. All staff training must be competency-based and is recommended to include specific steps and skills required to successfully execute plan implementation. Checklists developed should be used to guide training with demonstration, practice, and return demonstration to establish competency and subsequent rechecks for continued compliance.

6. Examine the process of team assessment that includes all the clinicians in one assessment with one individual. While the interaction can be valuable, routine participation by every clinician in this lengthy assessment process would likely take away from other necessary activities required for compliance with the Settlement Agreement.

7. OT/PT assessments should present a better picture of the individual and his or her baseline. This should include likes, dislikes, functional abilities, potential for skill acquisition, and analysis of barriers to successful life skills performance, and not only clinical discussion of impairments. Specific risk assessment must be included to ensure that supports and services coordinate to minimize these concerns and to identify the impact those risks have relative to participation in meaningful activities throughout the day. This analysis will provide the foundation for appropriate interventions to promote functional skill development and further recommendations of supports and services necessary for success. Goals should be measurable and meaningful to the individual. Creative use of groups should be considered because a group context can ensure greater capacity to provide appropriate therapeutic intervention.

8. Provide greater integration of therapy supports into the development of more meaningful programming in the day areas.

9. Documentation of therapy interventions should relate to progress toward achievement of a measurable goal(s). Therapy interventions should be included as an action step in the PSP. When discharge is anticipated, this may be reflected in quarterly reviews. In the case that therapy intervention is indicated in the interim, the specific need, rationale for intervention, specific measurable goals and discharge criteria should be documented in the form of a PSP addendum to ensure appropriate integration into the PSP process.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Dental policies and procedures, titled “Mexia State School Department of Dental Services, Dental Procedures” dated 7/1/09, and other associated documents o Dental records for the sample of individuals listed in section M above. <u>Interviews and Meetings Held</u>: o Dr. John Sponenberg, Dentist o Dental Hygienists: Rose Groth and Vicki Simmons o Dental Assistants: Bennie Kirven and Melinda Lopez <u>Observations Conducted</u>: o Dental facility
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor’s Assessment: Provision of dental care at MSSLC met the dental needs for this difficult population and included some innovative measures for improving the quality of dental health for the individuals.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for	This was an innovative program with full staffing and a functional setting for providing services and a commitment to providing the best dental care possible for each individual regardless of their physical or behavioral disability. Most individuals had attained at least a “fair” level of oral hygiene on a scale ranging from poor, fair to poor, fair, fair to good, and good. This required a push to get cooperation from direct care professionals. Many innovative efforts were successfully implemented to “woo” individuals into the dental chair. Most individuals in the facility were seen for recall at least quarterly, and some who presented with severe behavioral challenges, were seen weekly. The biggest problem was getting people to show up for appointments.	

#	Provision	Assessment of Status	Compliance
	persons with developmental disabilities shall satisfy these standards.	No mechanical restraints had been used in the facility for the provision of dental services. Personal restraint had been used, described as the holding of the individual's head very briefly to allow examination. Individuals who had been subjected to this type of a hold were usually stepped up to a more frequent recall. This allowed the appointments to be brief, and the oral health issues to be more controlled, so that procedures were not as complicated. The dental department used some very creative desensitization programs, although they were not labeled as such and were not part of a formal program. Nor was there documentation regarding the procedures. Nevertheless, for example, one individual with autism required three years before he would tolerate mechanical scaling. Most individuals who had difficulty coming to the dental suite had an autism component tot heir diagnosis and presented with some very complex sensory issues. Each individual with this issue had a different system for coaxing him or her into the dental suite with alternate plans having been designed to promote oral health until the dental department was able to implement more standard dental procedures. Dr. Sponenberg felt that the most important issue he faced was to get direct care professional level staff to value dental care. He described a number of approaches that were implemented to reinforce staff for good work, including awards for staff for supporting individuals with the most improved dental health. Another idea he discussed was to have a radio or music player on every unit that was programmed to play for the amount of time that individual should continue tooth brushing.	
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	Policies and procedures were available at the facility, but state developed policies to address this provision had not yet been disseminated. Even so, dental services were documented in the interdisciplinary treatment records for each individual reviewed.	

#	Provision	Assessment of Status	Compliance
	medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.		

Recommendations:

1. Consider the addition of support staff to assist with oral hygiene in the units with the most challenging individuals.
2. Ensure that there is upper level administrative support for the importance of oral care. This could do a lot to increase enthusiasm for oral hygiene on the living units.

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>: ○ Current Census Alpha ○ CVs for PNMT members ○ Continuing Education for professional staff ○ Habilitation Therapy Services, dated 02/22/10 ○ Communication Services policy #016, 10/07/09 ○ Communication Master Plan Data Base, dated 03/01/10, 03/04/10, and 03/26/10 ○ Master Plan for Communication Disorders, Revised 10/29/09, dated 03/26/10 ○ Communication Services policy (Client Management-41, dated 03/17/10) ○ Speech-Language Evaluation – Baseline template (POR-MR-9, 99/02) ○ Communication Dictionaries (approximately 100 submitted) ○ Speech Equipment Monitoring Sheet template ○ Speech Equipment Monitoring Sheet for Rehabilitation Therapy Tech template ○ List of Individuals with AAC 03/01/10 (from Master Plan data base) ○ Speech-Language Evaluation template ○ Speech-Language Evaluations for the following: • Individual #197, Individual #262, Individual #463, Individual #162, Individual #378, Individual #331, Individual #335, Individual #222, Individual #356, Individual #43, Individual #209, Individual #599, Individual #165, Individual #527, and Individual #461 ○ PSPs for the following: • Individual #197, Individual #262, Individual #463, Individual #162, Individual #378, Individual #331, Individual #335, Individual #222, Individual #356, Individual #43, Individual #209, Individual #599, Individual #165, Individual #527, and Individual #461 ○ Communication dictionary for each individual submitted ○ PNMP format ○ Dining Plan format ○ Occupational/Physical Therapy Services #014P, 11/04/09 ○ Quality Assurance monitoring reports for Section R: Communication by Kim Kirgan for the following: • Individual #108, Individual #340, Individual #405, Individual #481, Individual #383, Individual #256(11/30/09), Individual #375, Individual #323, Individual #208, Individual #432, Individual #548, Individual #31 (12/01/09), Individual #97, Individual #94, Individual #556, Individual #479, Individual #519, Individual #249 (01/01/10), Individual #39, Individual #467, Individual #401, Individual #532, Individual #4, and Individual #115 (02/01/10) ○ List of individuals with AAC devices, dated 03/01/10 ○ Speech Equipment Monitoring Sheets completed 01/10 through 03/10

	o Augmentative Communication Device Monitoring Sheets completed from 11/09 through 02/10 for the following: • Individual #282, Individual #431, Individual #234, Individual #56, Individual #47, Individual #251, Individual #474, Individual #4, Individual #88, Individual #46, Individual #148, Individual #250, Individual #347, Individual #597, Individual #448, Individual #261, Individual #131, Individual #228, Individual #53, Individual #368, and Individual #341 o Progress notes submitted from 10/09 through 02/09 for: • Individual #228 • Individual #448 o Audit of Speech Baseline Evaluations of New Admissions by Margaret Farrington, dated 03/22/10 o Audit Results Regarding Communication Master Plan by Margaret Farrington, dated 11/02/09 o Audit conducted by Margaret Farrington related to Modified Barium Swallow Studies and changes to Dining Plans, dated 08/25/09 o Audit conducted by Margaret Farrington tracking speech evaluations and progress notes o MSSLC Speech Processes Review conducted by Kim Milstead Ingram, Med, CCC-SLP and Janice Taylor, MS, CCC-SLP dated 09/17–09/18/09 o Staff Training documentation related to inservices conducted including medical communication, environmental controls, general communication boards, communication dictionaries, Super Talker, communication instruction sheets, Big Mack switch, augmentative and interactive communication, dated 10/09 through 03/10 o Staff New Employee training curriculum Interactive Communication o Meal Observation Sheets o Personal Record documents including: Personal Support Plans and addendums, Annual Medical Summaries, Nursing Annual and Quarterly Assessments for the last year, QMRP monthly reviews for last 12 months, NMT reports and screenings, Health Risk Assessment Tool, OT/PT Assessments and treatment notes, Communication Assessments/Updates and treatment notes (only assessment for Individual #405, dated 03/02/10, was submitted), OT/PT/SLP Consults, Modified Barium Swallow Study reports for the following individuals: • Individual #544, Individual #513, Individual #560, Individual #511, Individual #501, Individual #488, Individual #481, Individual #47, Individual #438, Individual #390, Individual #216, Individual #40 Individual #30, Individual #411, Individual #397, Individual #119, Individual #588, Individual #375, Individual #439, and Individual #77 Interviews and Meetings Held: o Coleen Range, MA, CCC-A, director o Kim Henderson, MS,CCC-SLP o Jean Reboli, MS, CCC/SLP o Cara Mattson, MA, CCC/SLP o Discussions with various supervisors and direct care professionals o Discussions with various day program staff

	Observations Conducted: o Mealtimes o Living areas and day program areas
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The speech and language department appeared to be operating in crisis mode and the lack of current assessments put the individuals who lived at Mexia at a distinct disadvantage. During the on-site interviews, the professional staff were clearly dedicated and committed to the process and genuinely cared about those they supported. The lack of current and appropriate assessment that addressed a contemporary model of AAC, led the monitoring team to be very concerned about the existing staff's ability to accomplish the tasks as outlined in the Settlement Agreement. They had made some small progress, but the workload will continue to grow exponentially, and the individuals who have waited so long for communication supports will only wait longer. It is imperative that the staffing level be increased to meet this daunting challenge. In addition, it is of concern that staff may attempt to lessen the load by taking shortcuts and making recommendations more in line with the resources available than basing recommendations on the specific needs of the individuals they serve. It will be critical to obtain general communication devices for use in the immediate future until such time person-specific systems may be more readily available. This will require intense staff training and compliance to ensure appropriate and effective implementation. There were significant opportunities for communication exchange and engagement in the home and day program areas, but the staff were not able to capitalize on those opportunities due to lack of support and training.

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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	The facility provides an adequate number of speech language pathologists or other professionals with specialized training or experience. At the time of the on-site tour, there were three full time speech and language pathologists. Kim Henderson, MS, CCC-SLP was a State employee and the other two, Cara Mattson, MA, CCC/SLP and Jean Reboli, MS, CCC/SLP were contract therapists. Ms. Henderson had been the only SLP for approximately five and a half years until April 2009 when the contract therapists were hired each of whom had worked at the facility in the past. There was one speech technician. Per the list submitted titled Habilitation Therapy Services (02/22/10), another clinician was listed, Stacy Catero, MS, SLP. Her resume was submitted as a member of the PNMT. She was not present during any of the meetings held with the department and was not identified as a clinician during the interviews with Habilitation	

#	Provision	Assessment of Status	Compliance
	assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	Therapy Services staff. The two contract clinicians were not included on this staff list. The Director of Habilitation Therapies was Coleen Range MS, CCC-A, an audiologist. A list of AAC-related continuing education was submitted for Kim Henderson, MS, CCC-SLP only. She had attended DADS-sponsored courses including "Communication Issues for Individuals with Developmental Disabilities," the "Assistive Technology Cluster Conference," and "PNMP for SLP and Augmentative Communication" during the last two years totaling 21 hours. There was no evidence that the other two clinicians had attended any AAC-related continuing education. The number of speech clinicians was of concern because each individual living at MSSLC communicated in some manner and, as a result, required the direct and/or indirect supports from a speech language pathologist resulting in caseloads of approximately 150 individuals each for communication, and the same 150 individuals each for oral motor/ mealtime. It was reported by the Director that there was an open position for a Speech Assistant. <u>Supports are provided to individuals based on need and not staff availability</u>. At the time of this on-site review, each of the three clinicians had a caseload of approximately 132 individuals in two critical service areas: communication and mealtime supports. Given this ratio, it would be extremely difficult to adequately meet the needs of the individuals at MSSLC. Basic supports would include at least an annual assessment or update, development of communication strategies for use by staff, communication dictionaries, dining plans, and the routine monitoring and revision required. This did not include those who would require direct speech-language services, more intensive supports necessary for using AAC systems, and/or attention to address increased risk for aspiration or choking during meals. As described below, assessments were not completed in a timely manner for a number of individuals in the sample and, as such, they would not receive appropriate communication supports and services.	
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	<u>All individuals have received a communication screening. If newly admitted, this occurred within 30 days of admission</u>. Per the tracking sheet submitted, 164 individuals had been screened and were rated at one of three priority levels related to augmentative communication as per the Master Plan for Communication Disorders (10/29/09): Priority 1 • Individuals who were non-verbal, who had a behavior plan, and who were not considered to be high risk medically Priority 2 • Individuals who were non-verbal, who did not have a behavior plan and were considered to be at high risk medically	

#	Provision	Assessment of Status	Compliance
	interventions.	• Individuals who were non-verbal without a behavior plan, all risk levels • Individuals who were partially verbal with a communication dictionary in place Priority 3 • Individuals who were verbal, with or without a behavior plan and all medical risk levels Per the Database submitted, dated 03/26/10, there were approximately 64 individuals considered to be Priority Level 1 or 15% of the census (450). Priority Level 2 individuals numbered 73 or 17% of the census, and there were 27 individuals considered to be Priority Level 3, or 6% of the census at MSSLC. There were four individuals listed as "UD" which was not defined in the Master Plan. Assessments for these individuals had not been completed per the Database. None of those prioritized had an assessment listed that was current within the last three years. The proposed date for each of these individuals to receive an assessment was generally "before" 06/30/10 (Priority 1), "after" 07/01/10 (Priority 2), and "after" 07/01/11 (Priority 3). There were no actual established completion dates for those identified with Priority 2 and 3 communication needs, only these "after" dates. Per an undated document submitted as part of the request for "all written products/reviews by Margaret Farrington as Habilitation Therapies Compliance Coordinator for the last 12 months," it was reported that baseline speech evaluations were delinquent for 14 individuals listed as new admissions from April 2009 through the "present." The initial review was completed on 07/20/09 with a follow up review completed on 09/29/09. At the time of the initial review, it was documented that 10 of 19 evaluations were not completed. At the time of the follow up it was noted that 5 of 19 were delinquent and that the speech assessments were delinquent for an additional 9 of 9 individuals admitted after 07/20/09 through 09/29/09. In a subsequent audit report, by Ms. Farrington dated 03/22/10, there were an additional 7 of 17 speech assessments identified as delinquent for individuals newly admitted to MSLLC. <u>All individuals identified with therapy needs have received a comprehensive communication assessment within 30 days of identification that addresses both verbal and nonverbal skills, expansion of current abilities, and development of new skills</u>. Per the Database, all those listed had received a communication assessment at some time, except for 19 individuals. Three of these had been identified as Priority Level 1, one as Priority Level 2, and one as Priority Level 3. The "last speech evaluation" or most recent evaluation was identified in the data base. Many evaluations had been provided as long as nine or ten years ago (47% of those identified as Priority 1, 2, or 3) and one individual (Priority 3) had not received a communication assessment in approximately 13 years. It would not be possible to appropriately determine if these individuals had communication therapy needs based on such outdated assessments. The priorities	

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		established were used to order assessments though the system allowed for assessment of Priority 3 individuals as far out as after July 1, 2011 to identify support needs with no established completion date.	

Year of Last Evaluation	Priority 1	Priority 2	Priority 3
2010	2	0	0
2009	1	0	1
2008	0	0	0
2007	0	0	1
2006	14	12	0
2005	12	23	0
2004	3	5	0
2003	0	2	0
2002	0	1	1
2001	28	22	19
2000	1	6	1
1997	0	0	1
No eval listed	3	1	1
Unknown	0	1	2
Totals	64	73	27

Another 272 individuals were not listed with any priority level and approximately 110 of those had received an assessment within the last 12 months. Approximately 37 of those with a recent evaluation were identified as nonverbal. Another 63 were identified as verbal and another 10 individuals had no designation as to their verbal/nonverbal status. The following individuals who were noted to be new admissions per their communication assessments were included in the above group: Individual #262, Individual #197, Individual #162, and Individual #463. Some others were noted to also be new admissions, which would explain why they had received assessments prior to some others with a high priority as established by the Master Plan, though this was not indicated in the database.

Individual #335, Individual #378, Individual #331, and Individual #222 were non-verbal and did not have a behavior plan, which would have placed them at a Priority Level 2 per the Master Plan. They did not have an assigned Priority Level per the Database, but were evaluated on 11/05/09, 08/19/09, 11/09/09, and 12/15/09 respectively, yet there were at least 60 other individuals who were a Priority Level 1 and had not yet received an

#	Provision	Assessment of Status	Compliance
		assessment. These four individuals did not appear to be new admissions to the facility and thus warranting assessment within 30 days. According to their assessments, they had been considered Priority Level 1 for communication assessment and supports with this designation intended for those who were nonverbal with behavior plans. None of these individuals reportedly had PBSPs. According to Individual #356's speech assessment dated 09/01/09, she too had been designated as a Priority Level 1, though this was also not reflected in the Database. The assessment stated that she had a behavior plan and was nonverbal, thus meeting the criteria outlined in the Master Plan. It appeared that perhaps this designation was dropped from the database once the evaluation was completed. It would seem important to retain each piece of data for tracking purposes, particularly information relating to how individuals were prioritized for assessment. There was evidence of numerous others listed in the database without current assessments. There were nearly 130 individuals considered non-verbal and as such would be identified as at least a Priority Level 1 or 2, yet they had not yet received a current assessment. In all of these cases, it had been more than three years since their previous communication assessment and, in nearly half of the cases, it had been up to 10 years ago. A request for the five most current communication assessments for each clinician was made by the monitoring team. A sample of only 13 assessments was submitted, five from Kim Henderson, and only four each from Ms. Reboli and Ms. Mattson. They included the following: By Kim Henderson, MS, SLP: Individual #43 (06/29/09) Individual #527 (07/14/09 Individual #209 (08/17/09) Individual #599 (08/17/09) Individual #461 (07/13/09) By Jean Reboli, MS, CCC/SLP: Individual #331 (11/09/09) Individual #335 (11/05/09) Individual #378 (08/18/09) Individual #356 (09/01/09) By Cara Mattson, MA, CCC-SLP: Individual #162 (11/23/09) Individual #463 (01/25/10) Individual #262 (01/21/10) Individual #197 (01/27/10)	

#	Provision	Assessment of Status	Compliance
		It was not clear why 10 of the 14 evaluations submitted were more than three months old. It would be expected that with so many evaluations to complete, there would have been many to choose from as "most current. In the sample of assessments reviewed by the monitoring team, there were 12 of 14 described as "baseline" assessments. Two of the individuals were identified in the assessment report submitted as Priority 1. Another report submitted was identified as a "full speech/language evaluation" for an individual also identified as Priority 1. Another was described as an "update" to a baseline evaluation dated 09/26/06, over three years prior, for Individual #461. He had received direct speech services in the last year to address articulation and intelligibility. It was stated that he had shown improvement and that there were no further recommendations for continued services. Of those reports submitted, five individuals were deemed to be effective verbal communicators and no further supports or recommendations were indicated by the clinician. Another two indicated that trials with AAC were attempted, but found to be unsuccessful (Individual #335 and Individual #378). Each was provided a Communication Dictionary. Individual #356, Individual #599, and Individual #222 were provided some type of assistive technology to address communication needs, while Individual #331 was offered only environmental control options rather than communication-based supports because he was deemed unable to comprehend messages or pictures. While the monitoring team was not familiar with this specific individual's skills, this rationale would not typically be an acceptable reason to deny communication-based supports. Individual #209 was also deemed unable to benefit from AAC, though she was able to briefly manipulate objects and produce adequate pressure to activate a switch, but "did not demonstrate interest in the cause-and-effect activities provided." Individual #527 and Individual #43 had received direct speech services during the year prior to their assessments. Each was discharged. At least four assessments were for individuals newly admitted and included Individual #463, Individual #262, and Individual #197. Each of these was completed within 30 days of admission. Each was identified as a verbal communicator and communication supports were not indicated per the clinicians. On the other hand, Individual #162's communication assessment report documented that the evaluation had been conducted on 11/23/09 with the report dated 12/08/09, however, the PSP also dated 12/08/09, indicated that the speech evaluation had not been completed at the time of the staffing. An "extension" was granted and an addendum meeting was to be held to discuss the findings. It was unclear why the evaluation was incomplete and the findings could not be discussed if the evaluation had been conducted two weeks earlier and also given that it was possible to produce the written report the same date as the PSP, but not for the	

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		meeting. Per his speech evaluation, he presented with a significant receptive language deficit (kindergarten to a first or second grade level), but was able to express himself at a much higher level. It was of concern that this assessment had not been completed within the appropriate timeframe of 30 days and pertinent information was not available to the team for the development of his PSP. Each of the assessments was of a consistent format and addressed diagnosis and health history and current status. Communication history addressed methods of communication and previous interventions. Further test results and clinical observations were the basis for sections related to receptive and expressive language skills, articulation and a brief discussion of augmentative and alternative communication/assistive technology. <u>If receiving services, direct or indirect, the individual is provided a comprehensive Speech-language assessment every 3 years, with annual interim updates or as indicated by a change in status</u>. The staff reported that annual updates were conducted for those who received supports. This was not apparent however from the assessments submitted because only two were identified as updates. Clearly, assessments had not been conducted every three years for any of the individuals living at MSSLC as was described above. There were nearly 140 communication assessments that were more than three years old, many significantly outdated. <u>For persons receiving behavioral supports or interventions, the facility has a screening and assessment process designed to identify who would benefit from AAC. Note: This may be included in PBSP</u>. The Master Plan identified people who were non-verbal with a behavior plan as the highest priority for assessment and supports, however, numerous other individuals had been assessed since the development of that plan who did not meet this criterion. For example, Individual #335, Individual #378, Individual #331, and Individual #222 were non-verbal and did not have behavior plans. They were not assigned a priority level, but were evaluated on 11/05/09, 08/19/09, 11/09/09, and 12/15/09, respectively. They did not appear to be new admissions to the facility thus warranting assessment within 30 days ahead of others considered to be of highest priority per the Master Plan submitted. <u>Individuals determined via comprehensive assessment to not require direct or indirect Speech Language services receive subsequent comprehensive assessment as indicated by change in status or PST referral</u>. A few of the assessments submitted described the provision of direct speech therapy within the last year including Individual #43, Individual #527, and Individual #209 (oral motor). Others received an Activity Plan and/or communication dictionary including Individual #599, Individual #356, and Individual #331. Individual #527 had reportedly received direct speech therapy to	

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		improve his intelligibility since September of 2005. In the baseline evaluation dated 07/14/09, the clinician stated that he had made progress in the last year, but his speech "is sometimes difficult to understand." The intelligibility of his conversational speech was described as fair, but understood by familiar staff and peers. The evaluation, however, reported that "direct speech therapy services are no longer a part of the Master Plan for Communication Disorders at MSSLC." It was further stated that he should be "dismissed from direct speech therapy services." It was of great concern that this was the rationale for discontinuing services at that time. Each of the evaluations or updates reviewed identified the need for at least indirect communication supports. At the time of this review, annual updates were completed (by report), though only one was submitted in the sample. Policy exists that outlines assessment schedule and staff responsibilities. The state policy dated 10/07/09 required review and revision of the "communication provisions of the PSP as needed, but at least annually." The Master Plan and Database were described to dictate the schedule of assessment rather than policy, though reference to the Plan was noted in the above State policy. Findings of comprehensive assessment drive the need for further assessment in augmentative communication. Assessment related to AAC was included in the comprehensive assessment format and update format for all communication evaluations. This section was generally quite brief, sometimes only a couple of sentences. As observed during the assessment conducted during the on-site visit, this was typically based on a brief trial of a couple of items in the AAC lab. In the case of Individual #356, it was reported in her evaluation dated 09/01/09, that she was not a candidate for AAC "at any level." Opportunity for manipulation of objects related to her daily routine was recommended, however, and it was suggested that this had been recommended also in the past but not implemented. During the assessment, it was further reported that she responded positively to a vibrating pillow presented. The clinician indicated that she was to be provided with one "with the intention of staff controlling it for her" rather than with a method to learn to control it herself or, more importantly, to develop a method to request it or ask for more when it stopped vibrating. There were approximately 42 individuals with some level of AAC including various voice output devices, wallets, and talking picture album, and so forth. Many of these appeared to be environmental control devices such as CD players, vibrating pillows, and fans, rather than more communication-based systems. Many individuals had been provided a Communication Dictionary per the Database.	

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R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP. For most of the sample, the evaluations findings were included in the Speech section of the PSP. In some cases, the findings of the speech and language assessment/update were not reflected in the PSP. Though none of the following individuals required AAC systems for communication because they were verbal, at least two of the three had communication deficits that impacted significantly on their behavior. • Individual #262 – There was no summary of the Speech assessment dated 11/5/09, and the PSP stated only that he was verbal and that his primary language was English under the general discussion section of his PSP dated, 02/09/10. • Individual #463 – There was no summary of the Speech assessment dated 01/25/10, and the PSP stated only that he was verbal and that his primary language was English under the general discussion section of his PSP dated, 02/09/10. The speech clinician indicated that due to receptive and expressive language deficits, he may be misunderstood or miss the intended meaning in casual conversations with others. He was admitted to MSSLC recently after being charged with sexual assault of a minor. The PSP further stated that he did not appear to understand why there are rules and why he should follow them. • Individual #162 - As described above, the speech assessment was "incomplete" at the time of his PSP. He had been newly admitted and presented with significant behavioral concerns. The PSP contains information regarding how the individual communicates and strategies staff may utilize to enhance communication. Specific information from the communication assessment was included in the Speech section under Assessments. There was limited other reference to communication elsewhere in the plan. This practice gave the impression that communication was the job of the speech clinician rather than an integral part of the individual's life. While staff would not be likely to fail to use speech to communicate or listen to the individual use speech to express himself or herself, when it comes to the implementation of AAC systems, it was viewed more as an activity or training program and was not well integrated into the individual's daily routine. AAC devices are portable and functional in a variety of settings. There were approximately 45-46 individuals provided assistive technology, though not all of it was communication-based. There were approximately 163 individuals considered to be nonverbal and who thereby had potential to benefit from AAC, yet less than 30% of these had some type of system beyond the Communication Dictionary. Many of the systems	

#	Provision	Assessment of Status	Compliance
		provided were for environmental control and with limited communication-based supports, including for example switches to turn on fans, CD players, and vibrating pillows. These were generally activities for the individual to do alone and would not readily promote communicative interaction or social engagement with others unless strategies were built in for the individual to request the item, for example. Though it appeared that the intent of the devices as prescribed by the clinicians was that they be portable and functional, the devices were not implemented throughout the day across settings and contexts. AAC devices are meaningful to the individual. Although only 40 individuals had AAC devices of some kind, they appeared to have the potential to be meaningful and functional. For example, during the OT/PT assessment observed, it was noted that Individual #498 reached for a person's hand and his drink. When the monitoring team asked staff what he liked to do, it was stated that he enjoyed going outside and to look out the window. The AAC evaluation conducted encouraged him to touch a switch to turn a light on and off, or a fan on and off. There appeared to be a disconnect between preferences, interests, and what was meaningful to Individual #498. Additionally, the assessment of his abilities in this area took less than 10 minutes and would hardly represent an adequate sample of his abilities. Only one speech assessment (Individual #405) was submitted in response to the monitoring team's request for portions of the personal records for those 20 individuals named above. He had received a baseline evaluation on 02/25/09 and this report, dated 03/02/10, was identified as an update to that assessment. He was described as able to blink his eyes twice for a "yes' response and blink once for a "no" response. It was also reported by staff that he held his breath to sound the alarm on his monitor to gain the attention of others. Recommendations indicated that programming should continue to focus on "developing his awareness of cause and effect" and to improve his level of independence through the use of an environmental control system that included a fan, vibrating pillow, and PowerLink device for access of other electrical devices. No AAC device was identified for this young man. It was unfortunate that the clinician did not recognize that Individual #405 clearly understood "cause and effect" if he held his breath to set off the alarm to get people to come to him, and that environmental control should not be provided in place of communication-based technology, but as an adjunct to AAC. Environmental control, in and of itself, and to the exclusion of a system to communicate beyond simple yes/no responses, was not meaningful or functional in this case. Ability without opportunity for participation results in meaningless, non-functional activity. Communication is engagement with others. Appropriate AAC must create those opportunities.	

#	Provision	Assessment of Status	Compliance
		Staff are trained in the use of the AAC. A two-hour training was provided to new employees related to communication and dysphagia and was not competency-based, other than a written test. This was evident in many cases. For example, direct support staff working with Individual #474 continually encouraged him to activate a switch that said something to the effect of, "Let's go outside" (it was difficult to hear the exact phrase). When Individual #474 finally swiped at the switch, it activated the message and she praised him, but put the switch away. When asked about the activity, the staff indicated that they were working on getting him to "hit the switch." When asked about when he would go outside, she stated that she could not take him out at that time. Thus, there was no reinforcement for activating the switch, let alone the intended outcome of communicating a desire to engage in a favorite activity. It was noted that there was no picture of the device in his PNMP, nor was there an activity plan to describe how the device was to be used. Individual #4 had a switch that said, "Hey, come talk to me." Staff responded to him, however, there was no picture of the device and no instructions as to its use. A request for staff training in the area of AAC for the last quarter was requested by the monitoring team. Training sheets and program descriptions were submitted for approximately 38 inservices conducted from 10/19/09 to 03/25/10. There was evidence of staff inservice training conducted by SLPs related to use of Communication Dictionaries, General Communication Boards, environmental controls, and in some cases person-specific devices such as a Cheap Talk, Super Talker, a PowerLink device, and Big Mac single message device. Communication strategies/devices are integrated into the PSP and PNMP. Refer to previous discussion regarding sections of PSP related to communication above. Communication strategies/devices are implemented and used. As stated above, a number of individuals had devices and communication strategies described for use, but there was limited evidence of functional use throughout the day. General AAC devices are available in common areas. A number of devices were available in common areas in several of the homes, including communication boards and boxes as well as environmental control devices. They were not observed in use during the on-site visit.	
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	Monitoring system is in place that tracks: a. the presence of the AAC; b. working condition of the AAC; c. the implementation of the device; and d. effectiveness of the device. Speech Equipment Monitoring Sheets were completed to address implementation of AAC systems for individuals who had them. Approximately 88 forms were submitted and each had been completed by Kim Henderson or the speech technician from 02/23/10 to 03/18/10. There was no evidence that monitoring had	

#	Provision	Assessment of Status	Compliance
	provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	been completed by any other staff during this time. The completed forms were for monitoring conducted across a variety of homes. The form addressed whether the communication dictionary was available with an instruction sheet and whether it was included in the PNMP. Another section was to address general and personal low/no tech communication systems, as well as high tech devices, and whether they were available and in good working order. In a number of cases the same concern was identified in multiple homes across a single week. For example, the Communication Dictionaries were not listed under assistive equipment in the PNMP over the course of at least one month across several homes or, in other cases, the device was locked away in the closet or nurses' station, or the batteries were dead, but the device was described by staff as broken. The monitors repeated the information each time, but there was no mechanism to track to whom it was reported and when the problem was resolved. By report, the data were not reviewed and tracked to identify ongoing issues to address through staff training. The current system may identify periodic issues with a couple of individuals' AAC devices, but will not ensure ongoing system change for improved implementation. There was no established method to ensure that each individual with a device was monitored on a routine basis. <u>Monitoring covers the use of the AAC during all aspects of the individual's daily life in and out of the home</u>. There was no clear consideration or schedule to ensure that each device was monitored across all aspects of the individual's day. <u>Validation checks are built into the monitoring process and conducted by the plan's author</u>. At the time of the on-site review, there was no evidence that validation checks were occurring at MSSLC to ensure ongoing consistency of findings between monitors and across time.	

Recommendations:

1. Aggressively recruit experienced speech clinicians to ensure all communication needs are appropriately met.

2. Revisit the current assessment schedule. In the case that ongoing assessments had been maintained, it would allow clinicians to address needs for AAC during this time using updates and implementation in a more timely manner. Clearly, with so many individuals without any kind of current assessment, it was of great concern that some individuals will not even receive an assessment for another year and a half, most of whom had been evaluated related to communication as many as nine or 10 years ago. There were insufficient speech staff to accomplish this task and simultaneously ensure that appropriate supports were provided. This could create an environment in which there might be a tendency for clinicians to skimp on assessment and choose to not make appropriate recommendations for fear they could not implement them.

3. Provide greater opportunities for continuing education opportunities for SLPs in the area of AAC to ensure that they have the knowledge and

skills to appropriately select AAC systems and to capitalize on individual communicative potentials, particularly for those individuals who demonstrate less overt communicative intent. It was recognized that DADS provided opportunities for continuing education; however, there was no evidence submitted that any continuing education had been attended by the SLPs at MSSLC other than Kim Henderson that focused on the area of AAC in the last year.

4. Ensure that AAC provided is functional and meaningful for individuals.

5. SLPs should take an active role in the mat assessments currently completed by OT and PT. Look at all aspects: swallowing, respiration, vision, motor skills, and switch access sites, in a variety of positions.

6. Ensure communication devices are available for general use.

7. Implement more communication during mealtimes. Individuals can initiate requests, interact with peers, and make social comments.

8. Initiate more opportunities for group interaction in the day programs. Model communication and interaction methods and strategies for staff in those programs.

9. Ensure that plans, assessments, and other documentation are consistent with regard to communication devices and how they are used.

10. Collaborate with psychology to design communication and behavior support plans to ensure coordination and effective intervention strategies.

11. Ensure that the monitoring system is regularly scheduled across all homes and is communication-focused to determine if the interventions and strategies that are being used continue to be functional, meaningful, and appropriately implemented.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Specific Program Objectives (SPOs) for: • Individual #507, Individual #300, Individual #238, Individual #401, Individual #592, Individual #42, Individual #276, Individual #528, Individual #176, Individual #489, Individual #221, Individual #444, Individual #353, Individual #361, Individual #419, Individual #530, Individual #115, Individual #63, Individual #330, Individual #101, Individual #134, Individual #38, Individual #216, Individual #271, Individual #236, Individual #387, Individual #517, Individual #292, Individual #88 o Personal Focus Worksheets (PFW) for: • Individual #300, Individual #238, Individual #401, Individual #592, Individual #42, Individual #276, Individual #528, Individual #176, Individual #489, Individual #221, Individual #444, Individual #419, Individual #530, Individual #115, Individual #63, Individual #330, Individual #101, Individual #134, Individual #38, Individual #216 o Positive Adaptive Learning Surveys (PALS) for: • Individual #300, Individual #238, Individual #401, Individual #592, Individual #42, Individual #276, Individual #528, Individual #176, Individual #489, Individual #221, Individual #444, Individual #419, Individual #530, Individual #115, Individual #63, Individual #330, Individual #101, Individual #134, Individual #38, Individual #216 o Personal Support Plans (PSP) for: • Individual #300, Individual #238, Individual #401, Individual #592, Individual #42, Individual #276, Individual #528, Individual #176, Individual #489, Individual #221, Individual #444, Individual #419, Individual #530Individual #115, Individual #63, Individual #330, Individual #101, Individual #134, Individual #38, Individual #216 o Six months of Progress Notes for SPOs for: • Individual #115, Individual #147, Individual #11, Individual #441, Individual #112, Individual #88, Individual #480, Individual #439, Individual #597 o Six months of Data Cards with Monitor's Notes for: • Individual #292, Individual #478, Individual #266, Individual #369 o Active Treatment Document (undated) o Education & Training Organizational Structure (undated) o Replacement Behaviors for: • Individual #462 (reviewed in Psych clinic), Individual #3 (from document request), Individual #488 (PBSP presented in BTC), Individual #559 (PBSP presented in BTC) , Individual #330 (PBSP presented in BTC), Individual #164 (PBSP presented in BTC), Individual #317 (PBSP presented in BTC), Individual #261, Individual #422, Individual #191, Individual #27, Individual #269, Individual #481, Individual #432, Individual #475,

	Individual #110, Individual #256, Individual #171, Individual #493, #327, #236, Individual #301, Individual #314, Individual #183, Individual #6, Individual #589, Individual #385, Individual #112, Individual #68, Individual #408, Individual #356, Individual #300, Individual #179, Individual #304 (from document request), Individual #513(from record found in Martin) o Memorandum of Understanding between MSSLC and Mexia Independent School District, dated 8/1/09 Interviews and Meetings Held: o Charlotte Kimmell, Ph.D., Director of Psychology o Deborah Hogan, Master Teacher; Gail McLain, Master Teacher o Paula Hayes, Active treatment coordinator for Longhorn o Don Morton, Education/Training Director o Norvell Starling, MSSLC liaison to the Mexia Independent School District Observations Conducted: o Observations occurred in every day program and residence at MSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training, etc.), and • Implementation of behavior support plans
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: There were many positive aspects of the skill acquisition programs reviewed at MSSLC. The commitment of the facility to individual skill building was evidenced by the allocation of staff dedicated to write and monitor specific program objectives (15 master teachers), and implement the plans (75 Education and Training Instructors). Consequently, the monitoring team found that specific program objectives (SPOs) were generally well written, closely monitored, and often resulted in the learning of new skills by many individuals. The plans, however, would benefit from the use of additional training procedures such as fading and shaping when necessary, more specific consequences for correct and incorrect responses, regular graphing of data, systematic preference assessments when necessary, and formal assessments of treatment integrity. On the other hand, all of replacement behavior plans (new behaviors developed to take the place of, or interfere with, undesirable target behaviors) were found to be missing critical training components (such

	as specific instructions), and measures of the integrity of staffs' implementation of the plans. Plans specifying the acquisition of replacement behaviors need to contain all of the components necessary for learning and skill development. Additionally, progress on the replacement behaviors need to be monitored, and instructional procedures modified as needed, based on each individual's behavior. The monitoring team was encouraged by the facility's commitment to active treatment by adding nine active treatment coordinators. The actual measures of individual engagement collected by the monitoring team indicated that improvement in individual engagement was needed in some settings. Although there was evidence of many community activities, there was no evidence that community activities were developed to address individual's needs for service or his or her preferences.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision incorporates a wide variety of aspects of programming at the facility regarding skill acquisition, engagement in activities, and staff training. To monitor this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. <u>Skill Acquisition Programming</u> Skill acquisition plans at MSSLC consisted of: • Specific Program Objectives (SPOs) that were written and monitored by 15 master teachers and primarily implemented by 75 Education and Training instructors (although direct care professionals did implement some of the SPOs), • Replacement and medical desensitization programs written and monitored by the psychology department. Replacement behaviors were also primarily implemented by DCPs, and • Habilitation Programs, written and monitored by specific rehabilitation professionals (e.g., physical therapists, speech language pathologists) and generally implemented by DCPs. The habilitation plans are discussed above in sections O and R of this report and, therefore, will not be discussed further here. Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures had just begun to be developed by the psychology department during the monitoring team's on-site tour. They had not, however, been implemented and, therefore, were not available for review for this baseline review. The monitoring team will be reviewing those in subsequent tours to the facility.	

#	Provision	Assessment of Status	Compliance
		An important component of effective skill acquisition programs is that they are based on each individual's needs identified in the functional assessment or PBSP, psychiatric assessment, language and communication assessment, Personal Support Plan(PSP), or other habilitative assessments. In other words, for skill acquisition plans to be most useful in promoting individuals growth, development, and independence, they should be meaningful to the individual and represent a documented need. The replacement behaviors were supposedly designed to replace dangerous or undesirable behavior with desirable behavior that would, ideally, take the place of the undesirable behavior. Teaching an individual to ask or sign for help to replace yelling or throwing items at staff to get their assistance is an example of a positive replacement behavior (e.g., signing) to take the place of a dangerous behavior (e.g., throwing items at staff). Therefore the replacement behaviors should be chosen based on the specific target behaviors identified in each individual's PBSP. Generally the replacement behaviors reviewed did represent needs documented in the PBSP. For example: • Individual #68's replacement behavior was increasing positive social interactions. This skill addressed the need to reduce attention-motivated aggression and inappropriate verbal behavior identified in his PBSP. • Individual #112's replacement behavior was to increase appropriate use of her hands while engaging in training or leisure activities. This skill addressed the need to reduce self-injurious behavior that often occurred during training and leisure activities identified in her PBSP. • Individual #488's replacement behavior was to increase participation in activities of daily living (ADLs). This skill addressed the need to decrease SIB, physical aggression, and disruptive behavior (e.g., yelling, screaming) that were hypothesized to be motivated by escape or avoidance of unpleasant activities (such participation in ADLs). The process for identifying specific SPOs for an individual began with the Personal Support Team (PST) where individual's preferences were identified. This meeting was followed by the completion of the personal focus worksheet (PFW) and the completion of the Positive Adaptive Living Survey (PALS) to identify adaptive and vocational needs which resulted in an individual's specific SPOs. Interviews with the master teachers indicated that they did attempt to incorporate preferences and needs in the development of each individual's SPOs. The rationale for why each individual's SPOs were chosen was included in the definition of each SPO, and was typically clear and logical. For example: • Individual #419 had a goal in her PSP to become more independent by increasing her pre-vocational and social skills. One of the SPOs chosen for her was to learn to operate a television remote control. The rationale stated that	

#	Provision	Assessment of Status	Compliance
		Individual#419 was fond of watching sports and cooking shows on TV, and it would enhance her independence if she were able to manipulate channels via a remote control. • Individual #517 had a goal to increase his independent living skills. One of the SPOs chosen was measuring with a ruler. The rationale for choosing this SPO was that Individual #517 stated that he enjoyed working in the woodshop. He was reported to be able to read the numbers on a ruler, but could not use the ruler to measure. The rational for this goal was that being able to use a ruler would increase his independence in the woodshop. Once developed, skill acquisition plans need to contain some minimal critical 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: • well-written behavioral objectives that define behavior and training conditions, • operational definitions of target behaviors, including a task analysis when appropriate, • specific instructions, • detailed and clear teaching instructions (e.g., shaping, prompting, fading of prompts), • specific consequences for correct and incorrect responses (including individualized use of positive reinforcement), • a plan for generalization and maintenance of the skill once mastered, • regular monitoring of results, and • modification or discontinuation if objectives are met or if progress has stalled. Using this standard, the comprehensiveness of the skill acquisition plans reviewed at MSSLC varied greatly. The best skill acquisition plans reviewed included the majority of the components listed above. For example Individual #238's SPO of self-administration of medication contained clearly stated behavioral objectives, operational definitions of target behaviors, and specific instructions. The monitoring team was most impressed by the consistent review of SPO progress and monthly notes (available in 100% of all SPOs reviewed) describing progress and data-based action for the next month. That action included the: • continuation of training (e.g., Individual #292 progress note dated 2/19/10), • discontinuation of a SPO due to achievement of the mastery criterion (e.g., Individual #238, note dated 2/11/10; Individual #353, note dated 1/8/10; Individual #361, note dated 2/16/10), • the addition of a new SPO due to the achievement of previous SPOs (e.g., Individual #517, note dated 1/8/10), • the modification of the steps of the SPO due to individual's performance on the	

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		skill (e.g., Individual #361, note dated 12/09/09; Individual #88, note dated 2/9/10), and • the retraining of staff due to poor documentation (e.g., Individual #517, note dated 10/2/09). On the other hand, none of the SPOs reviewed appeared to include the use of standard training procedures, such as shaping or the fading of prompts, specific consequences for correct and incorrect responses, or a plan for maintenance and generalization of achieved skills. The monitoring team believes that the effectiveness of the SPOs could be enhanced by incorporating the above components into their current procedures for developing and monitoring SPOs. The majority of the replacement behaviors reviewed contained few, if any, of the components of effective skill acquisition plans presented above. For example: • Individual #68's replacement behavior of Positive Social Interaction was operationally defined as interacting with others without engaging in any inappropriate sexual behavior, maintaining appropriate personal boundaries, and personal space. Additionally, although behavioral objectives of positive social interactions were clearly specified, there was no description of teaching conditions, no specific teaching instructions, and it was not clear how, or if, staff were trained to teach this replacement behavior. • Individual #27's replacement behavior was appropriately coping with feelings. This was defined as talking with staff when upset or when he does not wish to do something, using Stop-think-go decision making, applying the ACE (avoid, cope, and escape) technique, or using other calming techniques to better manage his behavior. There were no specific instructions for DCPs to train the behavior. It was not clear how well DCPs were familiar with the techniques specified. Additionally, this plan required staff to determine when Individual #27 was talking to them when upset, or when he is using another unspecified calming technique. Further, none of the replacement behaviors reviewed contained evidence that the skill was modified or discontinued based on each individual's behavior. Finally, the monitoring team was concerned about the reliability of the replacement behavior because the data collection and monitoring system was the same as that for behaviors targeted for decrease in the PBSP (see data collection comments in K4).	

#	Provision	Assessment of Status	Compliance
		Engagement in Activities: As a measure of the quality of individuals' lives at MSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. The monitoring team was pleased to learn that the facility was committed to improving active treatment among individuals by hiring nine active treatment coordinators, who assisted DCPs in scheduling and conducting active treatment in the residences. Engagement of individuals in the day programs and residences at the facility was measured by the monitoring team in multiple locations, and across days and time of day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program are listed below. Overall, the average engagement level across the facility was 59%. As can be seen in the table below, there was considerable variability across settings. An engagement level of 75% is a typical target in a facility like MSSLC, indicating that the engagement of the individuals had room to improve. The addition of the nine active treatment coordinators was a good first step toward improving engagement and attaining the goal of 75% engagement. The next step is for the facility to work on individualizing the activities scheduled, further staff training, data collection, and management of engagement. Individualizing refers to ensuring that engaging activities are preferred, and are appropriate to the skill capabilities of the individual. Another one of the most direct ways to improve active treatment is to objectively monitor individual engagement by collecting data, and establishing specific engagement goals in each home and day program site. Of course, variability across sites is expected, based upon the type and number of individuals and staff in each setting. A specific, detailed, and reliable method for collecting engagement data will be required. The process should also include the reporting of data to managers and staff.	

#	Provision	Assessment of Status	Compliance
		Engagement Observations:	

Location	Engaged	Staff-to-individual ratio
L1	8/8	4:8
L4	6/6	3:6
S5	3/10	3:10
Woodshop	3/4	2:4
Employment Center	7/19	5:19
Employment Center	4/4	2:4
Employment Center	7/7	3:7
Greenhouse	3/3	3:3
W8	3/6	3:6
W8	3/8	2:8
W2	3/4	1:4
W2	4/4	1:4
W2	5/5	1:5
W3	1/4	3:4
W3	1/8	4:8
M1	1/10	4:10
M1	3/6	4:6
M2	3/5	3:5
M4	2/9	2:9
M 7 & M8 (common room)	2/4	4:4
M 7 & M8 (common room)	2/4	2:4
W6	1/7	1:7
B1	1/3	2:3
B4	0/8	2:8
S2	4/4	1:4
S5	5/5	-
L1	5/8	3:8
L1	3/6	3:6

#	Provision	Assessment of Status	Compliance
		Educational Programming Many individuals residing at MSSLC were under age 22 and qualified for school educational services. The provision of educational services was the responsibility of the local school district, Mexia Independent School District (MISD). A few (15 or so) of the individuals went to school at MISD public school buildings off of the MSSLC campus. The remainder (approximately 60 individuals) attended a school program run by MISD on the MSSLC campus. MISD employees staffed this educational program. There were approximately five classrooms. Each classroom had a teacher and assistants. The program also had at least one behavior specialist. Further, two non-uniformed police officers were stationed in the school building. Observations by the monitoring team of the on-campus program found little engagement by students and little educational activity. During one mid-morning observation, 10 of 16 students in two classrooms (63%) were asleep on their desks, some with jackets over their heads while a video played on the television. The other students were outside supposedly at physical education, though it looked more like unstructured free time for the students. A memorandum of understanding existed between MSSLC and MISD. This document detailed the responsibilities of each party. Nevertheless, there appeared to be serious problems with the educational services provided to the students. During subsequent on-site tours, the monitoring team will explore this further. In the meantime, the facility and DADS need to assess and determine if these students are receiving the educational services to which they are entitled by state and federal law. Immediately following the on-site tour, a number of incidents occurred at the school programs during which aggressive behavior by individuals resulted in arrests and criminal assault charges being filed against these individuals. Two of these incidents occurred at an off-campus school program and one at the on-campus school program. Although violent behavior cannot be tolerated, it is possible, if not likely, that the environment created for educating these students, especially the environment on campus, might set the occasion for display of challenging behaviors by the individuals. Consider that the environment contained inadequately implemented PBSPs, little individualized curriculum, and the presence of police officers ready to restrain individuals who have long histories of problems dealing with authority figures. This latter need was one being addressed by MSSLC clinicians (although not without problems as indicated in section K above). Nevertheless, much work needs to be done by the facility, DADS, and MISD in order for successful educational services to be provided to these students. This issue has been brought to the attention of DADS and it is expected that more actions will be taken regarding this area across all facilities where relevant.	

#	Provision	Assessment of Status	Compliance
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.	As discussed above in S1, MSSLC conducted annual assessments of preference, strengths, skills, and needs. It was unclear, however, how the information from the PALS was used in any systematic way to choose skills. Additionally, while the PSP and PFW attempted to identify preferences, no evidence of systemic preference and reinforcer assessments was found (see section K5 above for additional comments on the need for systematic preference assessments). Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration. The monitors noted that some discussion of barriers to community integration often occurred at PSP meetings and in the living options section of the PSP. This issue is discussed in more detail in the review of provision T of this report, but also represents a source of information relevant to the choosing of skills that might be addressed for each individual using systematic instructional methodology.	
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	As discussed in S1, monthly data reviews by the master teachers resulted in data-based revisions or termination of SPOs. Review of monthly notes revealed several examples of SPOs that were successfully achieved (see S1). The monitoring team observed two staff conducting SPOs. In both cases (one in the woodshop and the other in the employment center) staff were able to articulate the SPO, the rationale for its use, the steps of the SPO, and the data collection procedure. Additionally, available data indicated that the plan was implemented according to the schedule specified in the SPO. None of the SPO data were graphed, however, and no direct measure of integrity of implementation of the plans was observed. The monitoring team believes that the graphing of individual's SPO data would aid the master teachers in data-based decision making, and inclusion of measures of integrity of implementation of plans would better ensure that SPOs were consistently implemented as written. The monitoring team reviewed the effects of 17 replacement behavior plans to develop or strengthen replacement behaviors that contained at least six months of acquisition data. Of those 17 acquisition plans, one showed consistent and sustained increase in the desired behavior (Individual #301). Despite the fact that the other 16 plans failed to	

#	Provision	Assessment of Status	Compliance
		show any meaningful or sustained change in the desired behavior, they continued to be conducted for several months without modification, suggesting that acquisition data were not regularly monitored, or modified as a function of the individual's behavior.	
	(b) Include to the degree practicable training opportunities in community settings.	At the time of the on-site tour, 36 individuals at MSSLC worked in the community. Additionally, many other individuals at MSSLC enjoyed various recreational and educational activities in the community. These activities included participation in Boy Scouts, various athletic programs in the community, off campus trips to places such as Six Flags, and participation at the PACE Center. The PACE Center was located in the community and served as an opportunity for individuals to participate in community activities, such as shopping, going to the library, and so forth. Six to eight individuals at a time attended the PACE Center daily. It was not clear, however, if these community activities were developed to address specific individuals' needs for services or preference. Subsequent tours to MSSLC will further evaluate the training individuals receive in the community.	

Recommendations:

1. Ensure that all skill acquisition plans (SPOs and replacement behaviors) contain the components necessary for learning and skill development.
2. SPO data should be graphed to aid in treatment decisions.
3. Develop a method to monitor if SPOs and replacement behavior trainings are implemented as they were written (treatment integrity).
4. Replacement behavior data should be monitored monthly, and programs should be modified based on the effectiveness of the plans.
5. Provide systematic assessments of individual's preferences when necessary.
6. Provide clear documentation that SPOs have been implemented to address needs addressed in assessments.
7. Develop a plan to address, monitor, and maintain reasonable levels of individual engagement in all settings.
8. Ensure that each individual is provided with training in the community that appropriately addresses his or her needs and preferences.
9. Ensure that individuals who are under age 22 receive the educational services to which they are entitled.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Most Integrated Setting Practices, 10/30/09, and six attachments (exhibits) o DADS Promoting Independence Advisory Committee report, January 2010 o MSSLC Mission Statement o Lists of individuals who attended community provider tours, included comments from staff, January 2009 through March 2010. o List of two individuals returned to MSSLC after failed community placement o Post-move monitoring schedule, updated March 22, 2010 o List of individuals who had a CLDP written since 7/1/09 and who have moved; the list had 53 names on it. o List of individuals who were discharged under the alternate discharge process since 7/1/09; the list had 27 names o List of alleged offenders, commitment type, and charge, dated 3/19/10; 147 names o MSSLC Community Placement Report; 7/1/09 through 1/31/10 o List of individuals assessed for community placement 7/1/09 through 2/25/10 o Director of Admissions and Placement referral list 7/1/09 through 2/25/10; 89 names on this list were in the referral process. o List of four CLDP meetings scheduled during the week of the on-site tour, all were on Friday, the day of tour exit, so none could be observed. o List of obstacles to placement 7/1/09 through 2/26/10: summary list and a detailed list for each individual. o Job descriptions: Director of Admissions and Placement, Placement Coordinator, and Placement Monitor o List of educational opportunities o PSPs for the following, selected by MSSLC • Individual #586, Individual #451, Individual #559, Individual #527, Individual #225, Individual #358, Individual #44, Individual #51, Individual #40, Individual #402, Individual #285, Individual #304, Individual #3, Individual #261, Individual #589, Individual #301 o PSPs for the following, selected by the monitoring team • Individual #450, Individual #381, Individual #19, Individual #45, Individual #512 o CLDPs for the following, selected by the monitoring team • Individual #595, Individual #490, Individual #381, Individual #219, Individual #19, Individual #167, Individual #45, Individual #512, Individual #192 o Post move monitoring checklists for the following, selected by monitoring team

	• Individual #595, Individual #54, Individual #450, Individual #490, Individual #381, Individual #219, Individual #19, Individual #167, Individual #45, Individual #512, Individual #192 o Risk assessment for: • Individual #192 <u>Interviews and Meetings Held</u>: o Alynn Mitchell, Director of Admissions and Placement o Sarah Hewitt, Post-Move Monitor o Lynda Mitchell, Facility Ombudsman and Rights Officer o Brenda Shoemake, Assistant Director for Programs o Thomas Harlow, MRA staff member who administered the CLOIP o Individual meetings with six individuals, representing all five units • Individual #40, Individual #470, Individual #353, Individual #479, Individual #316, Individual #409 <u>Observations Conducted</u>: o Two PSP meetings for: • Individual #314 • Individual #24 o Post-move monitoring home visit for: • Individual #192 o Self-advocacy meeting
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Overall, MSSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. The facility prided itself on its goal of supporting individuals to have successful community placements. MSSLC had indeed placed more than 100 individuals over the past 18 months. The goal of successful placement was felt throughout the facility, that is, in discussions with individuals and staff, during meetings, and in reviewing documents. As noted below, however, the facility must now ensure that safeguards are in place to ensure proper planning occurs for every planned placement. Review of planning documents and post-move monitoring indicated that many important supports were not identified for all of the individuals reviewed. MSSLC had a number of staff who were dedicated to providing most integrated setting options to individuals. Overall, the process and interactions observed between staff, family members, individuals, and non-facility providers were guided by respect for the individual.

	Each PSP reviewed contained a living options discussion and most included some discussion of the type of supports that would be needed if the individual were to move. Most of the discussions, however, appeared to be brief an/or done in a rote manner. The CLOIP was implemented for every individual reviewed. As indicated, below, it should not be considered to be an assessment for placement and further work will need to be done to create an assessment for each individual. MSSLC conducted a number of educational activities and participated in regular meetings with local MRAs. The facility also had the opportunity to re-start the self-advocacy group and include community placement, decision-making, and problem-solving as regulars topic for discussion. Modifications were recommended for improvements to the post-move monitoring process.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	MSSLC engaged in extensive activities to encourage and assist individuals to move to the most integrated setting. These activities were not always consistent with the determinations of professionals that community placement was appropriate (see comments below), and not always consistent with the individual's PSP (see comments below regarding CLDPs and post-move monitoring). These activities were, as required, not opposed by the individual or the individual's LAR, and appeared to be made by taking into account the greater issues of state-provided services. Upon arrival for the on-site tour, the monitoring team was presented with a packet of information about the facility. The cover page stated, "Our center is in the business of producing successful community placements by providing each individual with the opportunity to obtain skills and supports necessary to make a successful transition into an integrated placement in the community." Indeed, this perspective was seen throughout the facility and evident in the various discussions, meetings, and observations conducted by monitoring team members during the on-site tour. This was an impressive effort and, as a result, the facility reported a large number of transitions. Some details are below: • 67 community placements occurred in FY09 (September 2008 through August 2009). • 49 community placements occurred so far in FY10 (September 2009 through March 2010). • Of these 116 community placements over the past 18 months, 30 were individuals who were alleged offenders.	

#	Provision	Assessment of Status	Compliance
		• 122 individuals residing at MSSLC had been referred for placement and were at various stages in the placement process. • 76 individuals were admitted to MSSLC over this 18-month period. • All alleged offenders were required to receive a risk assessment prior to being referred for placement. Clearly, MSSLC had taken the Settlement Agreement provision requirements for most integrated setting practices very seriously and, as a result, many individuals had the opportunity to pursue and move into placements in the community. Throughout the on-site tour, monitoring team members met and spoke with individuals who were excited about their upcoming moves to the community. For example, at the Longhorn Unit, there were 15 upcoming transitions to the community. Individual #79, Individual #136, Individual #86, and Individual #453 all spoke very positively about their upcoming moves to group homes. Nevertheless, the monitoring team had concerns about the rapidity of movement and the high number of placements that occurred within a relatively short period of time. The facility's assistant director for programs and the facility's ombudsman reported that the process was conservative, that their goal was to have successful placements, and that risk assessments were required (as noted above). The monitoring team was glad to hear that these facility administrators were aware of these issues, but even so, had concerns because of the following: • Most of the CLDPs that were reviewed did not identify or include, what the monitoring team considered to be, many important essential and nonessential supports. This had the potential to reduce the likelihood of a successful transition and ultimately a successful placement and, moreover, possibly place the individual, housemates, staff, and community members at risk. Examples included the absence of behavior support plans, community psychiatry, counseling, and environmental safety precautions. More details are provided below in section T1c1. • Medical staff, especially physicians and psychiatrists, expressed concerns about the lack of their disciplines' involvement in planning for placement. They gave examples of individuals being discharged without their knowledge or input, prior to their completion of medical or psychiatric treatments, and without their opportunity to comment on the quality and depth of the community provider's capacity to meet the individual's needs in healthcare and psychiatry. • Individuals commented about other individuals who had moved into the community, but weren't ready to do so. Individual #321 made this comment during the self-advocacy group meeting. Other individuals nodded in agreement.	

#	Provision	Assessment of Status	Compliance
		• During Individual #24's annual PSP meeting, PST member comments related to barriers to placement were not thoroughly discussed. Moreover, it was possible that some team members may have felt their opinions were dismissed. For example, one team member noted a potential barrier. He was told that there were no barriers and he responded with a phrase such as, "No barriers? OK, whatever." • Many of the individuals placed or referred for placement had histories of challenging behaviors. The potential seriousness of a failed placement, especially if it involved an alleged offender, either juvenile or adult, and especially if the reason for the failed placement involved the injury of an innocent member of the community, could have severe consequences on the ability of the facility to continue to make placements in the community. MSSLC needs to provide assurances that transition planning is thorough, conservative, and based on a team process. The January 2010 DADS Promoting Independence Advisory Committee report noted the number of Home- and Community-Based Services (HCS) slots that were appropriated by the legislature. There were more than 5,000 slots appropriated and additional new slots were to be made available specifically for individuals living at SSLCs. No examples of funding as an obstacle were observed during this on-site tour or in any documentation reviewed. Nevertheless, two aspects of funding that the state should consider are (a) whether the funding determined by the individuals level of need at the facility will sufficiently fund the services needed in the community, and (b) whether success in the community will result in lower funding for a provider that in turn may result in fewer services to an individual. The monitoring team will examine these questions further on subsequent visits to MSSLC.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. The state developed a policy regarding most integrated setting practices and it addressed this provision item. It was numbered 018 and was dated 10/30/09. The purpose of the policy was stated in the first paragraph and noted that it was to encourage and assist individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the United States Supreme Court's decision in Olmstead v. L.C. The policy stated that it applied to all DADS SSLCs and numerous definitions were included.	

#	Provision	Assessment of Status	Compliance
		The policy also detailed procedures for assisting individuals with movement to the most integrated setting, identifying needed supports and services to ensure successful transition, procedures for identifying obstacles for movement, and post-move monitoring procedures. The policy also described procedures to meet other items in this provision of the Settlement Agreement. The policy called for encouraging individuals to move to the most integrated setting consistent with the determination of professionals on the individual's PST that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. The policy provided detail on the types of meetings, documents, and processes that were to occur. The policy did not specifically note that placement must take into consideration the statutory authority of the state, the resources available to the state, and the needs of others with developmental disabilities. The policy did, however, note that part of its purpose was to bring the state into accordance with the Olmstead decision. That decision specifically referred to these considerations and, therefore, these aspects did not need to be identified specifically in the policy. MSSLC had adopted the state policy in full. In addition, the facility had three other policies related to most integrated setting practices. The first was called "Community Placement." It was in the policies and procedures manual labeled as Client Management-12, and was dated 6/16/08. It was written to establish procedures for placement and discharge at MSSLC. It also included a requirement that a risk assessment had to be completed before a referral for placement could be made for individuals who were committed to MSSLC as alleged offenders, either juvenile or adult. It also noted that the designated MRA had to be present for a referral to occur. The second additional policy was called "Least Restrictive Environment," was labeled as Client Management-27, and was also dated 6/16/08. It established a procedure for determining least restrictive environment. The third additional policy was called "Placement Review Process." It was labeled Adminsitrative-21 and was dated 8/5/08. It detailed the procedures for review and appeal of placement recommendations when the PSP is unable to achieve consensus regarding a referral for placement. It also described a process for reviewing rescinded referrals and the cases of any individuals who returned to MSSLC from a failed community placement. Given that all three of these policies were created prior to dissemination of the DADS policy #018, and given that the contents of these three policies was similar, though not identical, to the DADS policy #018, the facility should (a) review these policies to ensure that they are not in disagreement with any of the contents of the DADS policy, (b) evaluate whether any of these policies could be eliminated because of the existence of the DADS policy #018, and (c) obtain some type of documentation of approval of these	

#	Provision	Assessment of Status	Compliance
		policies from the DADS central office discipline head. The monitoring team also looked to see if the policies and procedures were being implemented consistently. MSSLC staff were beginning to implement the DADS policy #018 and expected to eventually implement the policy in full. The Director of Admissions and Placement told me that they were part way through implementation and would continue to work towards full implementation, including addressing the quality assurance requirement in section T. The Director of Admissions and Placement was familiar with the new policy and its components. Further, the post-move monitoring position had recently been filled and PSP documents and processes included many of the requirements of this new policy. Alynn Mitchell was the facility's Director of Admissions and Placement. She was extremely knowledgeable about the placement process, discharges, transfers, admissions, and the placement of alleged offenders including the role and requirements of the Texas court system. She had worked at the facility for more than a dozen years, including positions in direct care and as a QMRP. The facility was very fortunate to have such an informed staff member in this important position. She was assisted by a placement coordinator and a post-move monitor.	
	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.	Sixteen PSPs were reviewed for the individuals listed in the Documents Reviewed list at the beginning of this section of the report under the heading "PSPs selected by MSSLC." All of these individuals resided at MSSLC. The PSP for each individual noted a variety of needs, required supports, and objectives for the individual while he or she lived at MSSLC. Information regarding the PST's review, consideration, and discussion of movement to the most integrated setting was found in the Living Options Discussion Record section of the PSP. Typically, this section of the PSP was less than one page long and indicated to the monitoring team that there was little comprehensive discussion about most integrated setting options for individuals. All 16 living option discussions included some indication of what the individual would need if a community placement were to be sought. The lists, however, were very similar, if not almost identical, across all of the reports (there were, however, some exceptions). Many of the living option discussions used the term "optimistic vision" when referring to living options. This was good to see. Following this term, however, was the phrase "reside in an alternate environment." This phrase gave little indication of any meaningful discussion about ways to support the individual and settings in which this type of support might occur. The phrase "reside in an alternate environment" was in the PSPs	

#	Provision	Assessment of Status	Compliance
		for Individual #225, Individual #358, Individual #51, Individual #40, Individual #261, and Individual #301. Typically, these PSPs also listed the same service needs for each individual: safety, medical, psychiatry, job training, 24-hour staff, case management, and transportation. Some of the PSPs indicated more individualization. For example, Individual #44's discussion included his preferred community recreational activities, special mobility and lifting needs, and the type of home that would be an "optimistic vision" for him if he were to live in the community. Individual #304's discussion included family preferences and different types of housing. Similarly, the discussion for Individual #451 included some of her favorite activities and items. Thus, MSSLC needed to do more to identify 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 as per this provision item. The living options discussion should include discussion about the ideal optimistic vision of the components of an environment that would best suit the needs and preferences of the individual, ensure safety, and provide adequate habilitation (including habilitative services, skill development and maintenance, and quality of life activities, such as leisure and recreation activities). Successfully facilitating this type of discussion will require specialized training of the person responsible. At MSSLC, each PSP meeting was facilitated by one of three specially trained staff members called PSP Coordinators. Their sole job responsibility was to facilitate and lead PSP meetings. This system allows for there to be thorough, in-depth training because it was such a small number of staff assigned to this responsibility. The monitoring team expects that this will occur along with DADS' development of new policies regarding Integrated Protections, Services, Treatments, and Supports (section F of the Settlement Agreement) and the person-directed planning process. Observation of two PSPs during the week of the on-site tour indicated other areas of focus for MSSLC as it works on living options discussion of the PSP meeting. Specifically, this part of the PSP occurred at the end of each meeting, often after lengthy reports were reviewed and certainly when most team members and individuals were tired and not as attentive as they were at the early part of the meeting. One of the PSP meetings observed was for Individual #314. The meeting was for a review after his first 30 days at MSSLC. The living options discussion portion of the meeting was short, rote, and allowed for little time or meaningful discussion. Standard questions were asked, such as whether to live in the city or country, whether to have a pet, and so forth.	

#	Provision	Assessment of Status	Compliance
		The annual PSP meeting for the other individual was attended by more than a dozen people, more than any other PSP meeting observed by the monitoring team. The large turnout was due, in part, to the individual's request and, in part, to the attendance by a member of the monitoring team. Early in the meeting, the individual gave a very coherent, impassioned, and lengthy description about what he wanted and what he needed in order to live a successful life. He wanted to do yard and lawn work. He wanted to do this work on the MSSLC campus and not be in the community yet, especially not around children. He said being around children was not safe for him. He said he felt ashamed about what he did, but that was in the past. Someday he wanted to have a family, children, and a relationship with a woman, but not now. The meeting continued and there was a lot of discussion about other aspects of his program and life, including rights restrictions. The individual became emotional during parts of the meeting and had to step outside. At times, members of the PST asked him questions that, to the monitoring team, seemed more appropriate for a private counseling session than for a PSP meeting. Nevertheless, the individual maintained composure throughout the meeting. After more than two hours, the living options discussion began. By this time, everyone in the room was tired. Some team members were planning to leave for other appointments and commitments. The discussion went on and included talk about an optimistic vision of a group home in another town, having his own room in an HCS home, living in the city, and having cable TV, a swimming pool, a garden, a car, and patio. There was some discussion about types of jobs, staffing, and the need for specialized programming for persons with a history of sexual offending. Although this may have appeared to have been a thorough discussion, observation indicated little participation from the individual and many team members. To summarize, two PSPs were observed, one was very brief, and one was extremely lengthy. In both cases, the living options discussion was late in the meeting and did not include an engaged discussion of a vision of what type of setting and supports would lead to success in the most integrated setting. DADS and MSSLC should consider moving the living options discussion to an earlier part of the meeting and consider reducing or eliminating the reading and presentation of informational data from written reports that are not needed for the important discussions required to occur at these meetings. All of the 16 PSPs addressed obstacles and barriers to placement by indicating that the obstacles to placement or noting that there were no obstacles to placement (e.g., Individual #559, Individual #527, Individual #358, Individual #44, and Individual #261). The most typical barrier listed was the exhibition of problem behavior (e.g., Individual #586, Individual #225, Individual #3). The discussions did not, however, include the detail required by the Settlement Agreement and the state policy regarding the development of a plan to address each identified obstacle. Any plan to identify and overcome obstacles should include strategies that:	

#	Provision	Assessment of Status	Compliance
		• are measurable, • identify a person(s) responsible for their implementation, • identify expected time frames for completion, and • are reviewed regularly and modified as necessary. Planning and discussing possible most integrated settings and addressing obstacles to placement may improve when other areas of service provision improve, including, as noted elsewhere in this report, the overall integration of services.	
	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.	MSSLC was engaged in a number of activities to educate individuals and their families or guardians to make informed choices. First, they held two annual provider fairs, one during each of the past two Junes. Numerous providers from the local communities attended. The parents association membership was invited, however, very few, if any, parents or LARs attended either fair. Admissions and Placement department staff reported that they tried to encourage LARs to attend. Second, the facility took individuals on visits to community providers. They used forms to document the trips. The documentation began in March 2009. Since then, there had been approximately 22 trips to about a dozen different providers. The forms showed the month's scheduled visits, the individuals scheduled to go on each visit, and a single page for each date of a visit with the names of the individuals who attended, the MSSLC staff who went on the visit, MRA CLOIP staff who participated, and comments about the visit experience. Overall, there were general statements about the visit going well. Many of the forms, however, indicated cancellations, delays due to MSSLC not being aware of the scheduled visit and therefore not having the individuals ready to leave MSSLC on time, problems with vehicle availability, and examples of community provider staff not being at the community residence for the scheduled appointment time. Overall, some type of summary data or tracking database was needed to determine if all individuals who were supposed to have these opportunities were indeed presented with these opportunities, the number of times each individual went on a visit, the goal and outcome of the visit for each individual, and whether the visit was in line with the information in the living options discussion section of the PSP. Third, although not solely related to education about community placements and providers, MSSLC was beginning to re-establish its self-advocacy group (as noted above). The activities of the self-advocacy group can play a large role in educating members of the group, as well as the greater population of individuals at MSSLC, about community living options. The group will need guidance and direction from the facility's ombudsman in order to be successful. Fourth, the Community Living Options Information Process (CLOIP) was implemented	

#	Provision	Assessment of Status	Compliance
		for every individual at MSSLC. The process was intended to provide information to individuals and LARs. The MRA contracted for the CLOIP at MSSLC was the Heart of Texas MHMR Center. Four staff conducted the CLOIP. The MRA staff attempted to educate each individual by establishing a relationship, doing interviews, showing pictures, and working with MSSLC to set up the visits to community providers. The MRA staff member interviewed described the CLOIP process in detail and talked about the many providers that were growing their programs to serve the needs of MSSLC individuals. Moreover, the Director of Admissions and Placement commented that the providers were being responsive to the need to grow. The monitoring team remained unclear as to the community's capacity for serving the many challenging and unique needs of the individuals at MSSLC, especially those with histories of alleged criminal offenses, sexual offenses, and substance abuse, as well as those with complicated medical and health care needs. In summary, MSSLC was in the early stages of developing and implementing a plan to educate individuals and their families and guardians. Further work will be needed to meet the DADS policy on most integrated setting practices, section III, paragraphs 1-7. LARs and PST members must be knowledgeable and be assured that the community has the resources to support individuals in these individualized ways. Safety, medical care, independence, and socialization are of the most importance to most family members and LARs.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. Thus, during the on-site tour, the monitoring team attempted to find out how MSSLC assessed an individual for placement. There did not seem to be a simple description of how MSSLC assessed an individual for placement. The Director of Admissions and Placement stated that the process included the PSP and PSP addendum, the PALS assessment, behavior programs, and risk assessment. She said that there was not a document that was called an "assessment for placement." The facility and the state need to determine how individuals are to be assessed for placement. This will likely require the development of a tool for this purpose. The assessment would need to include the individual's needs, strengths, and preferences. It should include what is required to address the individual's needs, support his or her strengths, and meet his or her preferences. The context of the assessment should be the PST's vision of the components and characteristics of an ideal living setting for the individual. The assessment should draw on PST members and family members/LARs.	

#	Provision	Assessment of Status	Compliance
		As noted in this report, some aspects of this process existed at MSSLC, such as some of the components of the PSP process, the living options discussion, and parts of the CLDP. The Monitors have raised this with the parties and expect for there to be resolution in the near future. The CLOIP should not be considered an assessment for placement. Its primary purpose was to document that attempts were made to inform the individual and LAR about community placement options and to document the individual and LAR's preferences for placement. The CLOIP was in place for approximately three years and, as a result, documentation existed for all individuals reviewed for this report. MRA staff reported that there was not much change from year to year for most individuals. The MRA staff also tried to gather information from the family/LAR. Over the past year, this was done by telephone for all but one individual. Nevertheless, as noted above, the monitoring team found a very active system of referral and placement at MSSLC. In a document called "Individuals assessed for community placement," 384 names were listed. Of these, 88 were indicated as being referred for placement (note that this number is different from that given above; this was not unusual given that the number of individuals on the referral list at MSSLC varied from week to week depending upon new referrals and completed placements).	
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 new DADS policy on Most Integrated Setting Practices, dated 10-30-09, included a section regarding the CLDP and an attachment outlining the components of the CLDP. At the time of the on-site tour, five individuals had transitioned since 7/1/09. A CLDP existed for each of these. A sixth individual was in the transition process and his CLDP was in development.	
	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 DADS policy on most integrated setting practices #018 provided detail on the development of the CLDP. The policy directed the PST to work in coordination with the MRA to develop and implement the CDLP in a timely manner. It also directed a representative of the individual's PST to submit a current assessment and/or discharge summary for inclusion in the CLDP. CLDPs appeared to have been completed for every individual who was placed in the community according to report by the Director of Admissions and Placement and according to documents listing the CLDPs. Nine CLDPs were reviewed. The nine names	

#	Provision	Assessment of Status	Compliance
		are listed above in the section "Documents Reviewed." These were for some of the individuals who were placed by MSSLC from November 2009 through March 2010. A key part of the state process was the identification of essential and non-essential supports. Essential supports were those program components that were required to be in place, that is, those that were essential to the success of the individual's transition. Non-essential supports were those that were very important, but would not serve to prevent a move from occurring. Even so, the expectation was that all non-essential supports needed to be in place and addressed. Non-essential did not mean not needed. Each of the nine CLDPs had a single-page table that listed out essential and non-essential supports, the person responsible for making sure the support was in place, and the target date for putting these supports in place. The table listed 10 areas of supports (e.g., residential, vocational, safety). These pages were similar across all CLDPs in their brevity and lack of detail. There were approximately 10 essential supports listed for each individual and a number of these referred to basic logical or bureaucratic processes (e.g., 24-hour awake staff, 30 days of medications, life safety code met, transition funds, reliable transportation) or to vague, non-measurable activities (e.g., "Getting to know you" inservice, special needs inservice for staff). The non-essential supports were similar across almost all of these CLDPs and included, for example, opportunities for interactions with appropriate peers, opportunities to participate in choice of activities, attending religious services of choice, day habilitation and employment, trust fund, and smoking area. MSLLC must improve the individualization of the essential and non-essential supports section of the CLDPs. More troubling than the lack of individualization of the essential and non-essential supports was the apparent absence of numerous supports in the CLDP that were indicated in other documents and assessments. Many of these supports were not only essential; they had the potential to be critical to the safety and success of the individual's placement. Their absence was of great concern to the monitoring team. Examples are provided below. • Individual #192: He had already moved to the community and was part of the post-monitoring visit discussed below. He had a history of serious violent behavior and inappropriate sexual behavior. The risk assessment conducted by MSSLC noted that, "his overall history would indicate high risk for re-offending in an environment of reduced or inappropriate supervision. With effective structure, supports and supervision, he may be considered as a low to moderate risk." The risk assessment noted that he would require a permanent restriction on access to knives and other weapons, and supervision of his time in situations involving children, females, or access to alcohol and/or illegal drugs. The risk	

#	Provision	Assessment of Status	Compliance
		assessment called for a number of very specific supports, including psychiatric services, specialized treatment programs for offenders and substance abusers, specialized ongoing counseling, and specialized counseling for this transition. The CLDP did not include any of these supports. Instead it merely listed 24-hour awake staff, 30 day supply of medication, special needs inservice for staff, life safety code met, another staff inservice, transition funds, and reliable transportation. • Individual #381: He had a history of failed community placements, stealing vehicles, and sexual assault. His documentation noted that he was "unable to control impulses" and had an antisocial personality disorder. In addition, he was involved in multiple allegations about staff abuse, sexual behaviors, and injuries during the 10 months prior to his placement. Recommendations included a BSP, psychiatric care, and counseling. Clearly, safety precautions were also needed. None of this was included in the list of essential and non-essential supports. • Individual #45: He had a history of sex offending and his living options discussion in his PSP noted that he would need to participate in sex offender therapy, have a BSP, have appropriate supervision, and live in a rural location. His CLDP noted these needs, too, but the list of essential and non-essential supports did not include all of these requirements. Fortunately, it included the requirement for participation in a sex offender treatment program, register as required by law, and have transition counseling. His placement, however, was in a residential neighborhood and a BSP and supervision were not included in the list of essential supports. • Individual #19: He had a history of criminal behavior, aggression, and auditory hallucinations. He was receiving a very high daily dosage of an antipsychotic medication. It was recommended that he have a BSP, participate in a 12-step substance abuse prevention program, and have counseling. In addition, PT reported that he needed to wear a brace when playing sports. None of these needs were addressed or included in his list of essential and non-essential supports. • Individual #219: He had a history of impulse control problems and inappropriate sexual behavior, including two incidents of inappropriate sexual behavior in the six months prior to his placement. He was receiving psychotropic medications. It was recommended that he receive specialized treatment and counseling during his first 90 days of placement. His CLDP did not address any of these needs and instead included references to a "special needs inservice." • Individual #490: Many of his challenging behaviors were related to cigarettes and restrictions on his cigarettes. Recommendations included a BSP, smoking schedule, psychiatric services, and counseling. None of this was included in his list of essential and non-essential supports.	

#	Provision	Assessment of Status	Compliance
		• Individual #167: His needs included participation in a 12-step substance abuse prevention program and counseling. Neither was included in his list of essential and non-essential supports. • Individual #595: He had a history of behavior, psychiatric, and sexual issues. Weekly counseling and psychiatric care were recommended, but not included in his list of essential and non-essential supports. • Individual #512: She had a variety of physical and medical needs. A BSP was recommended but not included on her list of supports. Her list of essential and non-essential supports, however, included some actions that were specific to her needs, such as ensuring that she had a specialized sleeping arrangement available, staff were trained to prevent her from falling, and there was consultation available with a psychiatrist and neurologist. The CLDP process must be modified at MSSLC to: • ensure that all needs identified in the individual's current assessment are indicated as essential or non-essential supports. o Some sort of QA check with supervisor approval will be needed for an additional review of this aspect of the CLDP planning process, • define each of these essential and non-essential supports in more detail, and • specify the support in a manner that can be measured or verified. In the weeks following the on-site monitoring tour, DADS central office and the facility reported to the monitoring team that actions were being initiated to address these above concerns. The monitoring team was not able to observe a CLDP meeting because the meetings were all scheduled for the Friday of the on-site tour. The monitoring team requests that the facility work with the monitoring team to schedule a CLDP meeting at a time earlier in the week during the next on-site tour.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDP essential and non-essential supports page did not indicate the facility (or provider) staff responsible, but it did list the timelines for completion. There was, however, no documentation as to whether these timelines were or were not met. The CLDP needed to identify specific facility staff. These CLDPs all listed "MSSLC staff" or the provider name, but no specific staff members (e.g., "Centex Staff," "D&S Staff," "United Bible Fellowship").	
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-	Signatures on each of the CLDPs indicated that individuals and guardians or LARS (when any existed or were appointed) were informed of the CLDP and participated in the process. Signatures of individuals were on each of the CLDPs, too.	

#	Provision	Assessment of Status	Compliance
	making regarding the supports and services to be provided at the new setting.		
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.	As per the DADS policy #018, current comprehensive assessments were provided to the receiving agency or provider as per report of the Director of Admissions and Placement. The documents for two of the individuals were reviewed in detail. Although numerous assessments were include, it was not possible for the monitoring team to determine if these assessments represented the full set of assessments relevant for the individual. Some sort of checklist or tracking tool should be used. If one already existed at MSSLC, it will be reviewed during the next on-site tour.	
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.	As noted above, there were serious concerns with the absence of essential and non-essential supports in all of the CLDPs reviewed by the monitoring team. In addition, the facility did not have a system in place to verify that the essential and non-essential supports identified in professional assessments were included in CLDPs, or at the individual's new home, before the individual's departure from the facility. Improvements to this process might include a more detailed listing of essential and non-essential supports during the living options discussion at the PSP meeting for those individuals who have been, or are likely to be, referred for placement. The Director of Admissions and Placement had other suggestions, including a modification to the PFW process. The PFW process was a way of gathering information prior to the annual PSP meeting. Usually the PFW process was done approximately 30 days prior to the PSP meeting. She suggested that the PFW incorporate a way for each discipline to be prepared to discuss essential and nonessential supports at the living options discussion section of the PSP. This suggestion should be considered by MSSLC management. At least two individuals at MSSLC had returned to the facility after failed placement in the community. Individual #16 had serious behavioral problems at the community placement and returned to MSSLC. Individual #230 walked away from the group home, ended up in an inpatient psychiatric unit, was arrested for public intoxication after discharge, and was returned to MSSLC. MSSLC had a process for reviewing these return placements, but the process should also include whether anything in the CLDP process might have played a role (i.e., whether appropriate essential and non-essential supports were included). Neither of these two individuals was on the current active referral list at the facility.	

#	Provision	Assessment of Status	Compliance
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	The quality assurance department's quality enhancement plan included section T. Data reported to the PIC were 94%, 97%, and 82%, for the recent months of December, January, and February, respectively. It was unclear as to what was being scored by the Director of Admissions and Placement. General quality assurances processes were discussed above in section E.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	MSSLC had done some work in this area. The Admissions and Placement department presented a document that listed obstacles to placement from 7/1/09 through 2/26/10. This list represented the obstacles to placement only for those individuals who had expressed a preference for placement, but were not recommended for placement. The obstacles listed were: - behavioral or psychiatric reasons 48% - LAR choice 25% - legal issues 18% - need for a risk assessment 13% As indicated in this provision item T1g, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles. Further, the listing of obstacles should also include those individuals who had not requested placement and were not referred. There was no indication that DADS had taken any appropriate steps to overcome or reduce these identified obstacles.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of	MSSLC presented a document called "MSSLC Community Placement Report." It listed individuals referred for community placement by their PSTs through the PSP process as well as those individuals who had been placed in the community during the previous six	

#	Provision	Assessment of Status	Compliance
	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.	months. On the list were 88 individuals who were referred for placement and 41 were placed in the community from 7/1/09 through 1/31/10. The list also included two individuals for whom a referral for placement was rescinded by the PST (one was the individual's choice, the other was the LAR's choice).	
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 had recently initiated the post-move monitoring process, including the recent hiring of the post-move monitor. The post-move monitor was knowledgeable about many of the individuals, the local providers, and the CLOIP process. The post-move monitoring forms were initiated in November 2009 and were going through revisions at the time of the on-site tour.	

#	Provision	Assessment of Status	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.	The post-move monitor maintained a post-move monitoring schedule that listed each individual's name, the new provider, and the dates by which the three required post-move monitoring visits were required to be completed. The facility was monitoring 16 individuals from MSSLC plus an additional individual who was placed in the facility's catchment area from Abilene State Supported Living Center. The monitoring team was pleased to see that the post-move monitoring process was in place and it appeared that the monitoring visits were occurring as per the required deadlines. All post-move monitoring was done on-site at the individual's residence while he or she was at home. An assortment of completed post-move monitoring forms were reviewed for the individuals listed above in the "Documents Reviewed" list at the beginning of this section of the report. Overall, the completed forms listed the essential and non-essential supports directly from the CLDP (but as noted above, many important supports were never included on the list). Many of the forms indicated that some supports were not in place, but there was no action plan described at the end of the form as required. An additional problem with the post-move monitoring process requires mention. That is, the manner in which the post-move monitor should determine the presence or absence of each essential and non-essential support needed to be specified. For example, the presence of the support was often determined based upon staff or individual report rather than on any type of documentation (e.g., 24 hour staff). Moreover, transportation may have been considered present if a van was at the home rather than a determination as to whether the individual had access to activities that required transportation or whether the van was available for individualized activities. The CLDP should be modified to include the type of evidence so that the post-move monitor knows how to assess its presence or absence.	
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	The monitoring team had the opportunity to accompany the post-move monitor on a visit to the home of one of the individuals who had moved to the community within the previous seven days: Individual #192. The monitoring team wishes to thank the post-move monitor and the community agency for making arrangements for this visit to occur. The purpose of this visit was to see the post-move monitoring process, see the community home, meet the individual, learn about transition and services, and see the status of some of the essential and non-essential supports. The individual had moved in less than one week prior to this visit. Two other individuals lived in the home. Each individual had a single bedroom. The home was single-story and simply furnished. It was located in a typical residential neighborhood. The post-move monitor began with an interview of the individual. The individual was responsive,	

#	Provision	Assessment of Status	Compliance
	monitoring and shall occur before the 90th day following the move date.	answered questions, and toured us through the house and bedroom. Overall, the individual appeared happy and to be settling in nicely. One staff member was present. He reported that he was the new house manager and had been assigned there only a few days prior to this visit, which was one day after the individual moved in. He was not knowledgeable about the individual's program and plan. Nevertheless, the post-move monitor obtained information from him regarding the individual's program. Important components of the individual's needed supports were not in place or could not be found, including: • the information placement packet sent by the facility • a vocational or day program • psychiatric consultation • behavior support plan • skill training plans • a correctly connected cable TV in the bedroom Moreover, serious problems with the CLDP's essential and non-essential supports were detailed above in section T1c1. Of course, due to the absence of these important supports from the CLDP list, the post-move monitor did not look for the presence of these important supports. The monitoring team looks forward to an improvement in the post-move monitoring process during the next on-site tour (e.g., improved lists of supports, specification of supports, specification of the manner in which the post-move monitor is to determine the presence or absence of a support).	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-	Numerous individuals were admitted to MSSLC for court-ordered evaluations. The provisions of this section T were not applied to those individuals as per this provision item. For these individuals, psychology staff at MSSLC completed (a) a determination of mental retardation, and (b) a determination of competency. The completed evaluations were submitted to the Director of Admissions and Placement with recommendations regarding competency and eligibility for admission to the facility.	

#	Provision	Assessment of Status	Compliance
	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 for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	MSSLC discharged a number of individuals as per this provision item T4. The Director of Admissions and Placement maintained a document called the Alternate discharge list. It listed each individual by name and discharge location. Most were discharged to a jail or other correctional facility. Some were discharged to another DADS facility or to his or her family.	

Recommendations:

1. Fully implement the new state policy on most integrated setting practices.

2. Ensure facility policies are in line with state policies, and obtain documentation from state office regarding the approval of state policies that add to, or supplement, state policies.

3. Review and modify how the living options discussion occurs at the PSP meeting regarding the optimistic vision for the individual's placement in the community. Consider moving the discussion to the early part of the meeting.

4. Address the identified obstacles to individuals' movement
    a. within the PSP meeting for each individual
    b. across the facility by conducting an assessment and by developing action steps from DADS.

5. Individualize the list of needed protections, services, and supports for each individual.

6. Create an assessment for placement as required by the provision item.

7. Improve the way important essential and non-essential supports are included in the CLDP:
    a. Ensure all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.
        i. define each support in observable and measureable terms.
        ii. define the manner in which the presence of each support will be verified.
    b. Ensure all professional disciplines are included in the transition and placement process, including, but not limited to, physicians and psychiatrists.
    c. Thoroughly discuss all PST members' concerns about placement, and consider all possible barriers to successful placement.
    d. Ensure that all relevant assessments are included with the CLDP.
    e. Add a component to the CLDP process to ensure that the above four recommendations (7a-d) occur, such as through actions of the QA department or senior management.

8. Assign specific facility and provider staff to all actions in the CLDP.

9. Develop a quality assurance process.

10. Continue to work on education of individuals and LARs regarding most integrated setting practices.

11. In the self-advocacy meetings, include discussion regarding choices, decision-making, and problem-solving related to, at a minimum, rights and community placement.

12. Revise the post-move monitoring checklist to include detail regarding (a) how the presence or absence of supports was assessed, and (b) follow-up activities for both essential and non-essential supports.

SECTION U: Consent	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o DADS Policy: Consent-Guardianship #019 dated 1/15/10 o List of individuals who have an appointed guardian o List of persons who did not have the functional capacity to render a decision and who also did not have an appointed guardian o Guardianship Log dated 9/21/09 o List of activities to recruit volunteer advocates and guardians from 10/09 – 2/09 o DADS 2009 "Your Rights in a State Supported Living Center" Booklet <u>Interviews and Meetings Held</u>: o Interview with Valerie McGuire, QMRP Director o Self Advocacy Group Meeting <u>Observations Conducted</u>: o Not applicable
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The state policy addressing guardianship was developed in January of 2010 and MSSLC had adopted the state policy. The facility had just begun to develop a list of individuals who needed an LAR and identify resources in the area. At the time of the on-site monitoring visit, 12 individuals had been identified as in need of a LAR and two local groups were identified as providers of guardianship services.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or	The state had developed a policy entitled "Consent and Guardianship" (Policy #019 dated 1/15/10) to address this provision of the Settlement Agreement. MSSLC had adopted the state policy without revision. The state policy mandated that the facility appoint a Guardianship Coordinator who will maintain and update, semiannually, a list and prioritization of individuals who lack both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision. The policy also mandated that the Guardianship Coordinator would create a	

#	Provision	Assessment of Status	Compliance
	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.	guardianship committee to determine which individuals on the list have the greatest prioritized need based on factors listed in the policy. These factors for determining priority need were in line with requirements of the Settlement Agreement. MSSLC had made some initial attempts to address this provision of the Settlement Agreement. Specifically, the facility had begun to identify individuals who lacked both the functional capacity to render a decision and an appointed guardian. At the time of the monitoring visit, 12 individuals had been identified and were assigned a priority level of one, two, or three. Only 92 individuals at the facility were listed as having a guardian according to a log dated September 21, 2009. Individual #101's PSP stated that she did not have a LAR. Her primary correspondent was a nephew, but the PSP stated, "Family contact was noted zero time during the year." The PSP further stated that she had a diagnosis of profound mental retardation with an IQ of 5, with a corresponding Mental Age of 1 year." The team had determined that she needed an advocate and was a Level 2 priority. Her name was added to the active waiting list for advocates. Based on information in the PSP ,it appeared that Individual #101 would be a priority 1 in terms of need for an LAR. There was no indication that she could make an informed decision in regards to her health or welfare. It was not clear how the team determined whether an advocate or an LAR was needed by an individual and how priority was assigned. According to the QMRP Director, PSTs had been directed to discuss the need for an LAR at each individual's annual PSP meeting. If the team determined that the individual needed an LAR, the QMRP submitted the individual's name to the Rights Officer. The Rights Officer was responsible for developing and maintaining the list of individuals who need a LAR. Guardianship discussion was observed at PSP meetings held the week of the monitoring visit. Although Individual #480's parents had been appointed as guardians and were active advocates for her, the team engaged in a lengthy discussion of options for guardianship if her parents were no longer able to advocate for her. Since she does not have other family members to provide this support, her parents were given information on pursuing corporate guardianship by PST members. The facility should continue to develop a list of individuals who need LARS and begin pursuing guardianship for those individuals according to assigned priority. In addition, the facility should ensure to pursue guardianship for individuals even if they have active interest and advocacy from family members. For example, during the PSP meeting for Individual #24, the PSP coordinator asked if the family was pursuing	

#	Provision	Assessment of Status	Compliance
		guardianship and the PST agreed that he had a caring family and, therefore, he didn't need a guardian.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The state policy addressed efforts that should be made to obtain LARs for individuals when the PST has determined there is a need for a LAR. The facility had made very little progress in regards to identifying resources for individuals who need guardians and/or advocates. They had contacted two local guardianship groups, Texas Guardianship Association, and Friends for Life and scheduled a meeting for 2/2/10 to discuss guardianship needs. The proposed meeting had been cancelled due to weather and had not yet been rescheduled. At the time of the monitoring visit, there had been no attempts made to secure guardianship for the twelve individuals identified as needing a LAR. This provision will be further reviewed during upcoming monitoring visits.	

Recommendations:

1. Continue identifying individuals in need of an LAR and prioritize the individuals based on ability of each individual to make informed choices regarding their health and welfare. Ensure the presence of caring family members does not preclude PST discussion regarding whether or not guardianship should be explored.

2. Continue to develop a list of LAR providers in the area.

3. Provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming a LAR.

4. Consider ways of teaching individuals to problem-solve, make decisions, and advocate for themselves. Some of these skills might be addressed with a formal instructional teaching plan.

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 Active records of various individuals on the residences or pulled for review by the monitoring team. <u>Interviews and Meetings Held</u>: o Elaine Schulte, Director or Records Department; Sherry Prince and Misty Samuels, Unified Records Coordinators <u>Observations Conducted</u>: o Not applicable
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: MSSLC had made some initial steps to prepare for implementing the new state policy on record keeping practices. The facility was waiting for more guidance from DADS regarding implementation of a new record order, including a new table of contents and guidance on how to create the new records. The facility records director and coordinators appeared eager to begin this new project.

#	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.	DADS had developed a policy on recordkeeping called Recordkeeping Practices. It was number 020.1 and was dated 3/5/10. It was slightly updated from a previous version in order to more thoroughly define each of the components of the unified record for each individual. MSSLC had its own policy, called "Documentation of services delivered to clients." It was labeled Administrative-30 and dated 1/30/07. MSSLC should review this policy so that it is in line with the new state policy. If the facility management decides to maintain an additional policy, approval from state central office should be obtained. The monitoring team looked to see if MSSLC had established and maintained a unified record for each individual consistent with the guidelines in Appendix D of the Settlement	

#	Provision	Assessment of Status	Compliance
		Agreement. At the time of the on-site tour, MSSLC was in beginning to make plans to implement and address this provision. Thus, the current records did not meet all of the criteria listed in Appendix D. An extensive review of the records was not conducted during this on-site tour because the records were going to be revised and reorganized The facility, as noted above, had taken some steps to prepare for meeting this provision. First, they recently hired two unified records coordinators who will have responsibility for overseeing the new systems, including conducting the review of records as required in section V.3. They worked under the direction of the facility's director of the records department, however, the positions might eventually be supervised by the QA department. Both unified records coordinators had attended a statewide training in Austin earlier in the month and learned about the new records systems and ways in which they could provide support to facility staff by making the records as user-friendly as possible. Program tech file clerks continued to be assigned to each of the units. The unified records coordinators were to have responsibility for setting up all of the record components and the file clerks were to have responsibility for maintaining them. It appeared that the individual notebook will contain some original documents (e.g., data sheets, daily observation notes from direct care professionals) that will only be removed and filed at the end of each month. The facility needs to consider, and plan for, the possibility of loss of an individual notebook or the disappearance of data or observation notes. This might be especially problematic if important data or critical observation notes were to go missing, especially if, for example, an investigation of an allegation of abuse was being conducted.	
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.	Over the past few months, DADS wrote and distributed new policies to address many, but not yet all, of the provisions of Part II of the Settlement Agreement. More work will be needed to complete the additional policies, and to develop a regular process for the review, updating, and modification of each policy.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement	A quality assurance procedure to ensure a unified record was not in place. The unified records coordinators had copies of the monitoring team's checklist tool and were planning to adapt it for their own monitoring. In addition, MSSLC's quality assurance department will be involved in addressing this provision item.	

#	Provision	Assessment of Status	Compliance
	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.		
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.	This provision item cannot be addressed until the records are organized under the new updated format and the new policy is fully implemented, including section IV of the policy.	

Recommendations:

1. Implement the new policy, including, but not limited to:
    - modify records following new record guidelines order (table of contents)
    - develop and implement quality assurance process
    - ensure records are used in making care, medical treatment, and training decisions.

2. Modify facility policy to be in line with state policy.

3. Review and consider the comments made above regarding aspects of the proposed new record keeping practices at MSSLC.

Health Care Guidelines

* Below, additional information is provided regarding two of the health care guidelines.

SECTION VI: Nutritional Management Planning		
		Summary of Monitor's Assessment: The NMT met monthly to address nutritional and physical management concerns with well documented meetings, however, the breadth of review by this group was more limited than that identified in the Health Care Guidelines. Additional comments are provided below regarding nutritional management planning as it related to items in this health care guideline section.
#	Item Summary	Assessment
VI1	Screen for nutritional risk, factors (5 items, a-e)	Individuals received a Nutritional Management Screening on an annual basis completed by the NMT in preparation for the PSP meeting the following month. It was not clear that this was provided for everyone at this time.
VI3	Diagnostic workup: diagnoses, tests, consults	The NMT met monthly and reviewed individuals with aspiration pneumonia, choking episodes, post swallow study, or tube placement, etc. (Others reviewed were based on scheduled reviews based on risk level or annual PSP meeting. There was no evidence of routine review of those referred for recurrent ear, nose and throat infections, GI bleeding, GERD, iron deficiency, wheezing in non-asthmatic, chest x-ray evidence of restrictive lung disease, recurrent dehydration, chronic underweight status, or recurrent emesis. For all that were reviewed for any reason, however, these concerns were generally reported as indicated. It appeared from the meeting minutes that only a portion of those with enteral nutrition were reviewed annually by the NMT.
VI3a	Possible treatments	Recommendations by the NMT for diagnostic testing were generally limited to modified barium swallow studies only, though others were also noted. The extensive participation by physicians and nursing was unmatched at other facilities previously reviewed by the monitoring team. The NMT is commended for this outstanding effort.
VI3b	Supportive care, PNMP	A PNMP was provided which addressed the following, at a minimum: diet texture/restriction, assistive mealtime equipment, physical alignment and positioning and mealtime guidelines as indicated. Special precautions, pace, and bolus size were not always specific in nature.
VI3c1	Treatment: dysphagia or aspiration / tubes	Position and alignment were addressed for all individuals with GERD precautions and enteral nutrition via the PNMP. Implementation of the PNMP in this regard was not adequate, however, for many as identified in sections O and P above. There was insufficient evidence that the PSTs had reviewed the continued medical necessity of enteral tube use for those in the sample reviewed including: There was no objective data used comparatively to make this determination and was not documented in the PSP.
VI3c2	GERD	See above
Recommendations: No further recommendations are presented beyond those already presented in section O above, Minimum Common Elements of Physical and Nutritional Management.		

SECTION VIII: Physical Management		
		Summary of Monitor's Assessment: Below are additional comments are provided regarding physical management as it related to items in this health care guideline section.
#	Item Summary	Assessment
VIII1	Screening for physical mgmt needs (7 items)	Individuals were provided a PNMP to address proper lifting and handling, use of assistive equipment, joint contractures, and muscle tone, and to promote and/or maintain comfort and good health. While assistive equipment was generally included to optimize independence when appropriate, supports provided by the clinicians did not focus sufficiently on skill acquisition, but rather on more acute concerns. These plans were reviewed annually by the clinicians and the PST and changes were made to the plans as indicated throughout the year.
VIII2	Screening for nutritional mgmt needs (5 items)	The PNMP included diet texture and liquid consistency, position and alignment, adaptive mealtime equipment and assistance strategies, including physical assistance and verbal cues and prompts.
VIII3	PNM techniques appropriate and all day	Plans were intended for use throughout the day, however, as noted in section O above, the PNMPs were not appropriately implemented throughout the day and all settings.
VIII4	PNM Plans easily understood, implemented	PNMPs were generally accessible. Staff were familiar with the format, however, as described in sections O, P, and R above implementation of plans was inconsistent and, in some cases, individuals were at risk of harm as a result.
VIII5	Ensure PNMPs accessible and include (7 items)	Dining plans were readily available in the dining rooms. The PNMPs were supposed to be maintained on the individual's wheelchair when appropriate. All plans had sections to address adaptive supports, mealtime, communication, physical supports and diagnoses, and health/medical concerns including: dysphagia, aspiration, nutritional health, circulation and history of fractures and skin breakdown.
VIII6	Data on PNM activities (5 items)	While not assessed in an interdisciplinary manner across all disciplines, OT, PT and SLP generally collaborated to assess and support issues related to aspiration, choking, pneumonia , need for specialized positioning, alteration of diet texture, problems and other related issues. The plans were reviewed to make modifications in supports based on changes in the individual's health status or on assessment of new strategies that provide more appropriate supports. PNM strategies to provide integrated supports for bedtime, bathing and repositioning were not consistently included, however, as described above, implementation of these plans was not always appropriate and the system to monitor implementation was not effective in identifying and resolving this problem.
VIII7	Systems for reporting need for re-eval or plan changes	There was not a clear review of each individual's risk indicators and what specifically was provided to them via the PNMP in a well-organized manner. Most of these concerns were listed in the health status review as a part of the annual OT/PT update and in the annual NMT review. The selection of strategies was not, however, consistently linked back to a specific risk indicator as in an analysis of findings. While some were associated in the body of the report it was not easy for the clinician(s) to ensure that each concern was effectively addressed via interventions and supports outlined in the plan.
VIII8	Overall monitoring plan for PNM plans	See section P

VIII9	Regular meetings held of the PNMT	The NMT/PNMT met monthly during 2009

Recommendations:

No further recommendations are presented beyond those already presented in section O above, Minimum Common Elements of Physical and Nutritional Management.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACE	Avoid, Cope, and Escape
ADL	Activities of Daily Living
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
BAS	Bachelor of Arts, Speech
BCABA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BMI	Body Mass Index
BSP	Behavior Support Plan
BTC	Behavior Therapy Committee
CAP	Corrective Action Plan
CASTMR	Competence Assessment for Standing Trial for Defendants with Mental Retardation
CCC	Clinical Certificate of Competency
CD	Compact Disk
CDDN	Certified Developmental Disabilities Nurse
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMS	Centers for Medicare and Medicaid Services
COTA	Certified Occupational Therapy Assistant
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curriculum Vitae
DADS	Texas Department of Aging and Disability Services
DCP	Direct Care Professional
DFPS	Department of Family and Protective Services
DIRM	Daily Incident Review Meeting
DISCUS	Dyskinesia Identification System: Condensed User Scale
DOJ	U.S. Department of Justice
ER	Emergency Room
FAO	Frequently Accusing Others
FAOTA	Fellow, American Occupational Therapy Association
FAST	Functional Analysis Screening Tool
FTE	Full Time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal reflux disease

GI	Gastrointestinal
HCG	Health Care Guidelines
HCS	Home and Community-based Services
HRC	Human Rights Committee
HST	Health Status Team
IACT	Interdisciplinary Approach to Client Training
IBW	Ideal Body Weight
ICFMR	Intermediate Care Facility/Mental Retardation
IDT	Interdisciplinary Team
IMM	Incident Management Meeting
IPE	Initial Psychiatric Evaluation
IPN	Integrated Progress Note
LAR	Legally Authorized Representative
LRA	Labor Relations Alternatives
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MAS	Motivation Assessment Scale
MBA	Masters, Business Administration
MBS	Modified Barium Swallow
MD	Medical Doctor
MHMR	Mental Health and Mental Retardation
MISD	Mexia Independent School District
MOSES	Monitoring of Side Effects Scale
MRA	Mental Retardation Authority
MRSA	Methicillin-Resistant Staphylococcus Aureus
MS	Master of Science
MSSLC	Mexia State Supported Living Center
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NPO	Nil Per Os (nothing by mouth)
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
PA	Physician Assistant
PACE	Programmed Activities for Community Engagement
PALS	Positive Adaptive Living Survey
PAWS	Practical Adaptive Work Skills
PAP	Papanicolau Test
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PEG	Percutaneous Endoscopic Gastrostomy
PET	Performance Evaluation Team

PFW	Personal Focus Worksheet
Pharm.D.	Doctor, Pharmacy
Ph.D.	Doctor, Philosophy
PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	Pro Re Nata (as needed)
PSAS	Physical Sexual Abuse Survivor Program
PSP	Personal Support Plan
PST	Personal Support Team
PT	Physical Therapy
QA	Quality Assurance
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
QSO	Quality System Oversight
RD	Registered Dietician
RN	Registered Nurse
RNP	Registered Nurse Practitioner
SA	Settlement Agreement
SATP	Substance Abuse Treatment Program
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPO	Specific Program Objective
STARS	Specialized Treatment and Rehabilitation Services
STEP	Skill-based Training for Employment Preparedness
STOP	Specialized Treatment of Paraphilias
SSLC	State Supported Living Center
SPO	Specific Program Objective
ST	Speech Therapy
TD	Tardive Dyskinesia
UD	Undiagnosed
UTI	Urinary Tract Infection