United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center
October 25-29, 2010

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Introduction

I. **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 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 ICF/MR component of Rio Grande State Center. In addition to the Settlement Agreement (SA), 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 (3) 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/her every six (6) months, and detailing his/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, were considered baseline reviews. Compliance reviews begun in July, 2010, are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of Richmond State Supported Living Center (RSSLC).

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.

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 October 25-29, 2010, the Monitoring Team visited Richmond 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), Behavior Support Plans (BSPs), 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. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, 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) **Facility Self-Assessment:** A description is included of the self-assessment steps the Facility undertook to assess compliance and the results thereof. Facilities provide the Monitoring Teams with such assessments 14 days prior to each onsite compliance review in the form of a Plan of Improvement (POI) that identifies Action Steps. Although the POI reviewed for RSSLC did not include complete descriptions of what specific activities were undertaken to accomplish Action Steps, RSSLC reported for each Action Step whether the Facility is in substantial compliance. It should be noted that the Action Steps listed by RSSLC are not fully in congruence with components of the SA that are being reviewed. The POI relies largely on retrospective record reviews as evidence, and this may not be sufficient to assess the actual processes and outcomes that will be assessed by the monitoring team. The Assessment of Status, therefore, reports on the findings of the monitoring team in relation to the provisions of the SA and may differ from the self-assessment by the Facility. The Monitor's reports began to comment on the facility self-assessments for reviews beginning in July, 2010;
(c) **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;
(d) **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;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. 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. However, it is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the SA.

IV. Executive Summary

At the outset, the Monitoring Team would like to thank the management team, staff and individuals served at Richmond State Supported Living Center (RSSLC) for their welcoming and open approach to this visit. It was clear that the State's leadership staff and attorneys as well as the management team at RSSLC had encouraged staff to be honest with the Monitoring Team. As is reflected throughout this report, staff throughout the Facility provided the Monitoring Team with information requested and were forthright in their assessment of the Facility's status in complying with the Settlement Agreement. Moreover, the facility made a number of staff members available to the monitoring team in order to facilitate the many activities of the monitoring team, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations. This was much appreciated and made possible an efficient and accurate review.

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 numerous 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.

Second, the monitoring team found management, clinical and direct care professionals eager to learn and to improve upon what they did each day to support the individuals at RSSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong onsite tour. All monitoring team members had numerous opportunities to provide observations, comments, feedback, and suggestions to managers. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist RSSLC in meeting the many requirements of the Settlement Agreement.

Positive Practices: The following is a brief summary of some of the positive practices that the Monitoring Team identified at RSSLC.

Restraint

- RSSLC policy clearly stated a prohibition of the use of prone restraint. The monitoring team did not discover any evidence of the use of prone restraint.
- Staff were current in restraint training and a curriculum review indicated the training presents appropriate content.

Abuse, Neglect and Incident Management

- RSSLC had a well-organized system for abuse prevention, detection, and reporting and a well-organized and managed system for incident management.
- RSSLC had done a good job training its staff about abuse and neglect. The monitoring team was able to validate substantial compliance with this Action Step.
- Compliance with required background checks was confirmed.
- Rights posters were in place across the Facility.

Quality Assurance

- RSSLC has taken important initial steps that can progress into a good QA system. The Facility had recently begun to develop and implement quality assurance processes that identify and remediate problems to ensure that the PSPs are developed and implemented consistent with the provisions of this section. The Facility used monitoring tools for each provision of the SA and had staff assigned to each provision. Monitoring was occurring and beginning to produce enough data to start generating reports. The QA staff was enthusiastic about their work and eager to see it impact facility operations. The monitoring team commends the Facility staff for this initiative overall although it could be improved by carefully documenting follow-up quality improvement activities and then tracking them to ensure the improvements have taken hold.

Integrated Protection, Services, Treatment and Supports

- The new PSP policy and process had been initiated, staff were being trained, and monitoring of annual PSP meetings was in place.

Integrated Clinical Services

- T he clinical pharmacist began attending the morning physicians' meeting each Wednesday. Psychiatrists had also begun attending the Wednesday morning meeting. This provides an opportunity for integrated discussion of cases and issues.

Minimum Common Elements of Clinical Care

- There were signs of progress on completing scheduled assessments and establishing an interdisciplinary process that may lead to recognition of changes in health and behavioral status that need timely response.

- Scheduled assessments were completed timely for most disciplines. There was progress on establishing an interdisciplinary process that may lead to recognition of changes in health and behavioral status that need timely response.

Psychiatric Care and Services

- The Facility achieved substantial compliance with requirements of the SA provisions that related to psychiatrists' qualifications and psychiatric staffing levels, and the SA provision that required campus-wide screening for psychopathology.
- In the past the Facility relied heavily on after-hours contractors who could not attend PST meetings. The Facility had now hired two staff psychiatrists, who should be available to participate more fully in the Personal Support Team (PST) process. Both psychiatrists started to work at the Facility just prior to the monitoring team's tour.
- To be available for desensitization programs to reduce need for pre-treatment sedation, the dental suite area was reserved for one afternoon each week for the administration of dental desensitization protocols.

Psychological Services

- The Director of Behavioral Services possessed all required qualifications. He also was participating in classes and supervision, and anticipated sitting for the board certification exam within the next several months.
- The degree of progress noted in promoting enrollment in BCBA training was admirable. The number of Behavioral Services staff enrolled in courses relating to BCBA credentialing increased substantially. This was positive, although a minimum of 18 to 24 months will be required before these staff would be prepared to sit for the board certification examination.

Medical Care

- The monitoring team noted progress in some areas of medical services. The monitoring team is pleased with progress made in developing work groups to address clinical pathways for common and serious clinical conditions.
- The initial phase of development of an infection control data base, policies for hydration, peer review process and superficial skin infections were also noted to be of benefit to individuals served at the Facility.

Nursing

- The Nursing Department was able to consistently meet minimum staffing ratios without the use of agency nurses.
- It was a positive finding that the QA Department and Nursing Department had adopted, implemented, and trained the Nursing Leadership, Nurse Managers, and Nurse Case Managers in the Settlement Agreement Monitoring Tools.
- The Quality Assurance Nurses had begun analyzing and trending data outcomes from the result of their findings from the Settlement Agreement Review Tools.
- All reviewed Annual and/or Quarterly Nursing Assessments were completed according to their Personal Support Plan schedules.
- The Infection Control Department worked collaboratively to develop a much improved database for tracking and trending infection control data. The purpose of this improved database system was to collect meaningful and valid data that can be utilized to trend over a designated date range as well as to quickly assist clinical staff in identifying emerging infectious issues so that the Facility staff can address them expeditiously. Infection Control Officers had begun completing an analysis of Pneumonia from Infection Control tracking data. The Infection Control Workgroup had updated all Infection Control Policies and Procedures since the baseline review.

Pharmacy Services

- The review team noted the high quality of professionalism offered by the clinical pharmacist at the Facility and has determined that the Facility is in substantial compliance with Provision N2; however, additional benefit to individuals served and potentials for significant saving on enhanced drug utilization could be achieved by increasing the number of clinical pharmacists and strengthening the pharmacy review process.

Physical and Nutritional Management

- Positioning instructions for wheelchair and alternate positioning were included in PNMPs as applicable.
- Transfer instructions were included in PNMPs as applicable.
- Mealtime/dining plans included intake information for mealtime and snacks.
- Mealtime/dining plans included food/fluid textures as applicable.
- Mealtime/dining plans included behavioral concerns related to intake.
- Individual adaptive equipment was included in PNMPs as applicable.
- Karen Hardwick of State Office led a competency based webinar to review and provide feedback regarding competency based forms for lifting and mealtime. Another topic of conversation was how to better improve implementation of strategies during mealtime. Discussed forms were placed on a shared drive so that all the state centers could review and provide feedback. This was a positive step not only as it relates to overall care but to improve consistency between SSLCs.
- OT/PT assessments included evidence of active collaboration between OT and PT. All included signatures and date of both OT and PT.
- OT/PT plans and PNMPs were developed within 30 days of the date of the assessment/update as indicated by the assessment.

Dental Services

- Dental Service at the Facility was managed well professionally, had acceptable documentation practices, and utilized an excellent behavior incident report.
- To be available for desensitization programs to reduce need for pre-treatment sedation, the dental suite area was reserved for one afternoon each week for the administration of dental desensitization protocols.

Habilitation, Training, Education, and Skill Acquisition Programs

- RSSLC Self-Advocates attended the statewide annual self-advocacy conference and there is a plan in place to assist them to become members of the Fort Bend County self-advocacy group in the community.

Most Integrated Setting

- RSSLC had undertaken a number of initiatives that were intended, at least in part, to assist PSTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs. Included among those was the implementation of the new statewide PSP process on October 1, 2010
- Since the last monitoring visit, RSSLC had engaged in some educational activities about available community placements to individuals and their families or guardians to enable them to make informed choices, and 13 individuals had transitioned to community living. There had also been 15 CLOIP community tours since the last monitoring visit in April, 2010. A total of 114 individuals had attended these community tours, with a few individuals attending more than once. While the CLOIP continued to be the primary vehicle for providing information about community living options to individuals, LARs and family members, on two occasions it was noted that individuals visited friends in the community. The monitoring team commends the Facility for encouraging this type of awareness activity, as it allows individuals to maintain relationships while also gaining a better understanding of how community living might be relevant to their own lives.

- For individuals who had been referred for transition, the Facility had begun to make documentation of provider search activities, including the trial visits individuals made and their reactions to these through PSP Addendum meetings.
- DADS had issued its first annual Obstacles Report for the State Supported Living Centers in October, 2010, which provided guidance to the Centers as to the methodology and categories of obstacles to be used in order to ensure the State Office receives comparable data from each one. The monitoring team found the report to provide excellent guidance to the Facility regarding the types of obstacle data to be collected, such that it may be collated and provide an accurate picture of the obstacles to be addressed both in the catchment areas and the state as a whole. This will, of course, be dependent on how well the PSTs can accurately identify the obstacles.

Consent

- PSTs were making a number of referrals to obtain advocates for individuals in lieu of seeking legal guardianship. This was a commendable approach to obtaining decision-making assistance for individuals while preserving their legal autonomy, but the Facility had not yet implemented a formal advocacy program.
- The Facility was taking a measured approach to the issues of guardianship as it awaited the promulgation of statewide DADS Policy Number: 019 Rights and Protection, and this was to be commended.
- The Facility was to be commended for its approach to self-advocacy as a means to promote the capacity of individuals to make informed decisions.

Recordkeeping and General Plan Implementation

- The new DADS recordkeeping policy and Active Record format following the Active Record Order had been implemented for all individual records. Training had been provided.

Areas in Need of Improvement: The following identifies some of the areas in which improvements are needed at RSSLC:

Restraints

The RSSLC policies that govern restraint were not in alignment with DADS policy on restraint. As a result, implementation of RSSLC restraint policies will not ensure compliance with the SA. DADS policy on restraint addresses the requirements of the SA and it will be important to the RSSLC that its policies reflect DADS policy in order to achieve SA compliance. This incongruity was most notable in some of the basic terms used in the SA compared with terminology in RSSLC policy.

RSSLC did not use the DADS-required Face-to-Face Assessment/Debriefing form to assess the circumstances of each restraint. DADS policy requires that a Safety Plan be developed for any individual who was restrained 4 or more times in a rolling 30 day period. The RSSLC had nine individuals who met these criteria. None had a Safety Plan.

The RSSLC had not at the time of the review fully implemented the revised Restraint Checklist issued as a policy revision by DADS in June.

Review of the documentation relating to all form of restraint usage indicated that nurses did monitor individuals who were restrained but failed to consistently notify the physicians prior to use of chemical restraint, inform the physician of assessment findings when notifying the physician of chemical restraint use, or notify the physician when the individual's blood pressure dropped below baseline after receiving psychoactive medication.

Abuse, Neglect and Incident Management

Review of documentation of reporting identified several incidents of late reporting.

There was clearly a problem with timely response from the Department of Family and Protective Services (DFPS) in initiating investigations. Initial investigatory activity often exceeded the 24 hour requirement, sometimes by days.

The competency-based nature of training needs improvement.

Quality Assurance
RSSLC had a quality assurance policy and as of 10/4/10 a draft quality assurance plan. Both documents provided general direction and, while lacking specificity at this point, represented a good beginning point for additional development. RSSLC will need to ensure, as it continues to develop quality assurance plans, that the plans address all aspects of facility operations that impact services to individuals, including a written medical review system component, a written nursing quality assurance component, and a written medical quality improvement component. Current quality assurance is observably more organized than what was observed during the baseline review. There is still substantial work ahead in developing meaningful reports and analyses.

There is some question as to whether staff using the monitoring tools were sufficiently trained in knowing what to look for and how to assess each data item being monitored. For example, some QA reports showed a high degree of compliance that was not evident to the monitoring team during observation in the course of the review (e.g., certain elements in the meal monitoring tool). RSSLC will need to ensure that staff tasked with monitoring, especially monitoring with clinical components, have a sufficient depth of knowledge to accurately report monitoring observations and results.

Integrated Protections, Services, Treatments and Supports
DADS issued new policy direction on PSP development on 7/30/10. RSSLC received training on the new policy in August, 2010. RSSLC began training its staff on 8/23/10 and reported over 400 staff had been trained by the time of the compliance visit. The new PSP format and process was implemented at RSSLC on September 1, 2010. At the time of implementation, and at the time of the monitoring visit, not all staff had received initial training on the new process.

The DADS policy is being implemented without the benefit of a RSSLC specific policy. The target date set by the RSSLC for a local policy is 12/1/10.

Integrated Clinical Services
Integrated planning is beginning to occur but was not yet routine.

The new PSP process promotes integrated planning but had just begun implementation at RSSLC. Participation documented in PSP meetings included numerous clinicians. Although progress had been made in integrating clinical services, disciplines still operated relatively independently of each other when carrying out assessments and developing interventions.

Review of risks of interventions by the PST was not thorough and was not always reflected in the PSP, even when individual clinicians identified those risks.

PST members whose participation was essential due to an individual's needs were not always present during planning meetings.

Minimum Common Elements of Clinical Care

Assessments in response to changes in function or status were not always done, and such changes were not always evaluated thoroughly even through the annual assessment process. Changes in status were not always recognized and reported, discussion awaited scheduled meetings, and there were not thorough assessments when there was decline in function.

Assessments were not always based on current evaluations and did not always include summaries or rationales to explain how evaluation results led to conclusions and recommendations.

Use of clinical indicators for review of progress was variable, which might be one reason why changes in status did not lead to action.

At-Risk Individuals

The deficiencies in the at risk system described in the baseline report will continue until a new system is developed and implemented. These deficiencies are primarily the lack of objective criteria from which to assess risk which resulted in high risk individuals, or individuals at high risk in one or more assessment areas, not being rated high risk and, therefore, not likely to receive the intensity or frequency, of treatment needed to mitigate risk.

Psychiatric Care and Services

At the time of the compliance tour, about 60% of individuals who needed psychiatric assessments had received them. The evaluations were detailed and their overall quality was good, although they did need to better identify the particular behavioral characteristics of the psychiatric disorders that were diagnosed.

Medication treatment plans that were required by the SA were not yet in place. The monitors were informed that several Facility work groups have formed, and that these will address SA requirements related to behavioral healthcare. Unfortunately, the process was at an early stage and no specifics were available for review.

A required process to track psychiatric polypharmacy was in place, but a needed component that monitored efforts to reduce unnecessary polypharmacy was not.

A required Facility wide process for tardive dyskinesia screenings was in place, but a needed process that identified and monitored individuals with positive screenings was not.

Psychological services

The Facility had only one staff member who was board certified, with three additional staff approved to sit for the examination in the coming several months. This may continue until staff who are in process of becoming qualified as behavior analysts complete training and certification. This lack of demonstrably competent staff will substantially limit the ability of the Facility to address several areas of the Settlement Agreement.

The Facility also reported that the Behavioral Services department had established several workgroups to develop recommendations regarding changes needed to achieve compliance with the Settlement Agreement. This is a positive step, as such workgroups could be very helpful to the process, but almost a year had passed in the Settlement Agreement process before the groups were established, and they are in early stages of their work.

For the majority of individuals living at RSSLC, there was no assessment of behavioral, intellectual, or adaptive functioning that conformed to accepted practices. The process for reviewing behavior assessment and intervention plans lacked formality and failed to ensure that assessments and interventions conformed to accepted practices.

The review process for ensuring safe and effective intervention often required several weeks, delaying the implementation of treatment plans and potentially subjecting individuals to unnecessary risk.

Numerous limitations in data collection procedures were documented during the site visit. In addition, many reviewed records reflected an inability of the facility to effectively monitor responses to interventions and conduct the necessary modifications to assessment and intervention plans.

The Facility did not employ a competency-based approach to staff training. In the majority of cases, training on PBSPs was typically conducted only when the PBSP was first implemented. In addition, the Facility had not developed or implemented a system to ensure that pulled or relief staff were provided with training on PBSPs.

Medical Care

The Facility needs to ensure Advanced Practice Registered Nurse practice is within the legal limits of the Nursing Practice Act, that supervision is provided according to provisions of the Medical Practice Act, and that practice reflects the actual training of the Advanced Practice Registered Nurse.

Physicians must be more comprehensive in their assessments and do their best to determine the etiology of conditions diagnosed by them. Clinical records and documentation practices remain an area of concern for the Facility.

The mortality review process was inadequate and must be revised.

There were 19 employees who were delinquent for two or more years in their Cardiopulmonary Resuscitation (CPR) Basic training. The version of the BLS Healthcare Providers Training Manual by the American Heart Association was dated 2006 and was four years old.

A mock medical emergency drill was conducted in the Infirmary at 12:02 p.m. on 10/28/10. Unfortunately, the drill was failed. The establishment of the Emergency Medical Response Committee was a positive finding and should facilitate improvements in the Emergency Medical Response system. The Emergency Medical Response Committee needs to develop and implement a written procedure to guide the Committee's functions. Committee membership needs to be broadened to include representatives from other relevant disciplines, particularly physicians.

Nursing Care

Nursing department has room for improvement in documentation, assessments, and notification of physicians promptly of acute illness and injuries.

Although steps had been taken to address infection control, there remains much improvement to be made in preventing or control infectious disease process, particularly aspiration pneumonia.

Significant progress had been made since the baseline review in an effort to improve medication administration practice and reduce or minimize the incidents of medication errors, as evident in reviewing medication error data. Medication Administration Observations for oral medication and enteral administration were completed monthly on nurses administering medications, and actions were taken as needed. The Medication Error Policy needs to be expanded to include all medication variances. The Medication Error System of analyzing and trending medication error data was not easy to understand and needs to be revised so it can be clinically useful.

Although many systems had been implemented since the baseline review and much effort had been put forth by the Nursing Department in moving toward compliance, more time is needed for the systems to be refined and to mature before compliance with the Settlement Agreement can be achieved.

Pharmacy Services and Safe Medication Practices
The Facility had made no progress in the areas of utilization review, drug variances, and monitoring for Metabolic Syndrome.

Physicians accounted for significant prescribing variances that had the potential for serious adverse outcome and pharmacists.

The Facility had no database system specific for pharmacy applications such as drug variances, utilization review and adverse drug reactions.

Pharmacy related committees such as Pharmacy and Therapeutics (P&T) and the Nursing Medication Error Committee must be evaluated and restructured to be more efficient and efficacious.

Physical and Nutritional Management
There is an immediate need to address monitoring of all aspects of increased PNM risk. Monitoring did not cover staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). Currently, monitoring remains focused on mealtime. This must be addressed as quickly as possible due to the high risk of aspiration occurring outside of dining.

A Physical and Nutritional Management Team (PNMT) had been formed and had been meeting regularly. The Physical and Nutritional Management Team was found not to meet the standards identified in the settlement agreement. Currently, the team was only providing assessments once per week to review individuals on a scheduled basis but did not meet in response to potential areas of PNM decline. The PNMT was not addressing system issues. The PNM team consisted of a qualified Speech Therapist (SLP), Occupational Therapist (OT), Physical Therapist (PT), Registered Dietitian (RD) and Registered Nurse (RN) but did not consistently include a Physician or Behavior Analyst. Due to the medically high risk nature of the individuals who will be the focus of the meetings, a physician would be needed so that a true comprehensive discussion may be provided and medical implications addressed. Additionally, because many issues associated with physical and nutritional decline are linked to behavioral issues, a behavior analyst would be a valuable member of the team.

DADS was in the process of developing a new risk policy and procedure that is planned to address the need to more accurately identify an individual's risk. Individuals who were at risk were not being accurately identified by the existing risk system resulting in individuals being place at an unnecessary risk of harm. Individuals who have had skin breakdown, fecal impactions, or aspiration pneumonia were mostly listed as being at a low risk. Additionally, the two individuals who were listed as high risk were not provided with a comprehensive care plan to mitigate the risk.

Supports regarding the areas of oral care and medication administration were missing from the assessment process and were not included in the PNMP.

PNMPs were not regularly reviewed in the occurrence of a change in status and were not comprehensive due to the plans lacking information regarding oral care and medication administration.

Staff was observed not implementing PNMPs and not displaying safe practices that minimize the risk of PNM decline. Individuals were observed poorly positioned and with safe dining strategies not implemented. Per interview, staff were not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being. There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual.

All Individuals did not receive an annual assessment that addressed the medical necessity of enteral feeding or potential pathways to oral status. Those individuals who did receive assessments did not have clear justification as to why the tube was necessary nor did the assessments list possible pathways to oral intake.

Physical and Occupational Therapy
Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills.

RSSLC had opened up two more positions for PT which should assist in lowering the caseload but these positions had not been filled as of this review. Assessments were completed in accordance to the schedule set forth by RSSLC; however, assessments were not being consistently completed in response to a change in status.

Intervention plans related to positioning were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. Examples of this were Head of Bed (HOB) elevations.

Plans were not implemented as written and staff were not knowledgeable of the OT/PT plans. A system did not exist that ensures staff responsible for positioning and transferring high risk individuals receive training on positioning plans prior to working with the individuals. Based on interviews of DCPs, staff did not consistently understand rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the OT/PT plans and /or PNMPs.

Dental Services
Many of the provided documents were newly developed outlines of policies and procedures for dental services.

Dental service had a limited referral system and did not utilize mechanical or physical means to safely support individuals during dental procedures.

As noted in Section J, programs to minimize need for sedation were in place, but there was a lack of involvement of the PST in decisions about sedation and integration of these programs into the PSP. Importantly, following review of annual PSP, the monitoring team notes a significant lack of involvement of dental issues in general through the team process.

Communication
The current ratio for Speech Pathologist to clients was approximately 1 to 66. This ratio may be functional once all systems have been revised and implemented but is not enough to address the issues that have been identified by the Settlement Agreement.

The Communication Assessment did not consistently address expansion of current abilities and development of new skills. A new assessment was developed but was not implemented during this review.

Alternative and Augmentative Communication (AAC) devices were not consistently portable and functional in a variety of settings. RSSLC was monitoring the presence and working condition of the AAC devices but was not monitoring whether or not the devices were effective and or meaningful to the individuals.

SLPs were in the process of developing a priority list for AAC evaluation. Per the priority list, all individuals will be assessed by 2013. This is an unreasonable timeframe as many individuals who are nonverbal or have identified speech difficulties will go without proper assessment for multiple years.

DCPs interviewed were not knowledgeable of the communication programs.

Habilitation, Training, Education, and Skill Acquisition Programs
The majority of skill acquisition programs involved good organization, the basic elements of sound data collection, and a logical approach to teaching a skill. Despite these strengths, there was no indication that attempts were being made to utilize formal practices associated with successful learning. For example, programs included only a limited number of trials and a subjective process for selecting reinforcers rather than identifying reinforcers through reinforcer and preference assessments. In addition, data collection did not include documentation of the type or frequency of reinforcement.

Observation also reflected that staff had not been provided sufficient training on specific formal programs. Staff typically could locate individual programs and data sheets, but often demonstrated that they were uncomfortable or unsure about implementing the programs.

Most Integrated Setting
New statewide policies had been issued in conjunction with the roll-out of the statewide PSP process, but these were not yet incorporated into Facility policies and procedures.

Observations and document reviews during the monitoring visit indicated the Facility continued to need improvement in the areas of interdisciplinary assessment, individualized assessment of need for supports and services in the most integrated setting, and development of individualized strategies for education about community living options to promote informed choice.

The Post-Move Monitor was diligent and effective in her efforts. PMM Checklists were being completed in a timely manner. There were some instances in which the Post-Move Monitor did not adequately document the presence of supports, or follow up on an item to close the loop and document the resolution of the concern or need.

Consent
The Facility had made no significant changes to its tools or processes since the previous monitoring visit, in anticipation of the issuance of the statewide policy. The Facility expected to operationalize this policy once it was made available. In the interim, the assessment process for need for guardianship remained undefined and dependent on the processes of the particular PST.

The Facility continued to maintain a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision. The placement of the individuals on the list was not made according to any standardized assessment, as described above, but did utilize certain specific criteria to determine a numerical priority. It was expected this prioritization process would be modified according to the requirements of the pending statewide policy.

While awaiting policy guidance from DADS, the Facility had not taken steps to enhance recruitment of guardians.

Recordkeeping and General Plan Implementation
Although most records were in generally good order, review of records found errors in filing, some missing assessments, some illegible entries (particularly signatures), and gaps that were not crossed through.

An audit process for Active Records had begun. Audits used the review checklist tool developed by the monitoring teams. and identified deficiencies, but the process of monitoring was informal, did not include written feedback or requirements for corrective action, and had no procedure to determine whether corrective actions had been completed or to track and trend the findings of the audits.

Policy development and revision to support all provisions of Part II of the SA continued at both the statewide and Facility levels.

Use of records for decision-making was variable. There was little review in PSP meetings of the prior year's progress or regression and little focus on using data from the records to make decisions.

Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
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.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DADS Policy #001: Use of Restraint, dated 8/31/09 2. DADS Policy #015: Dental Services 3. RSSLC Plan of Improvement (POI) 5/17/10 4. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10 5. RSSLC Policy J.1: Use of Restraint (9/1/09) 6. Draft Revision to RSSLC Policy J.1: Use of Restraint (11/1/10) 7. RSSLC Policy J.2: Using Restraint in a Behavioral Emergency (9/1/09) 8. Draft Revision to RSSLC Policy J.2: Using Restraint in a Behavioral Emergency (11/1/10) 9. RSSLC Policy J.3.01: Using Restraint in a Safety Plan – Contingent Restraint (8/1/08) 10. Draft Revision to RSSLC Policy J.3.01: Using Restraint in a Safety Plan – Contingent Restraint (11/1/10) 11. RSSLC Policy J.3.02: Using Restraint in a Safety Plan – Protective Restraint (8/1/08) 12. Draft Revision to RSSLC Policy J.3.02: Using Restraint in a Safety Plan – Protective Restraint (11/1/10) 13. RSSLC Policy J.4.01: Using Restraint during Medical/Dental Procedures (8/1/08) 14. Draft Revision to RSSLC Policy J.4.01: Using Restraint during Medical/Dental Procedures (11/1/10) 15. RSSLC Policy J.4.02: Using Restraint to Promote Healing/Recovery (8/1/08) 16. Draft Revision to RSSLC Policy J.4.02: Using Restraint to Promote Healing/Recovery (11/1/10) 17. RSSLC Policy J.5: Using Restraint to Prevent Involuntary Self-Injury (11/15/04) 18. Draft Revision to RSSLC Policy J.5: Using Restraint to Prevent Involuntary Self-Injury (11/1/10) 19. RSSLC Policy J.6: Using Restraint to Provide Postural Support (11/15/04) 20. Draft Revision to RSSLC Policy J.6: Using A Restrictive Intervention to Provide Postural Support (11/1/10) 21. RSSLC Policy J.8: Documenting Significant Behavior Incidents (4/19/05) 22. RSSLC Policy J.9: Conducting Interim for Repeat Incidents of Aggression (11/17/03) 23. RSSLC Policy J.10: Submitting Positive Behavior Support Plan for PSP, Peer Review Committee, and HRC Review (2/5/08) 24. RSSLC Policy J.11: Using Sedation for Medical/Dental Appointments (3/10/10) 25. RSSLC Policy J.12: Intervention and Documentation for Suicidal Behavior (2/27/08) 26. RSSLC Policy J.13: Implementing Dental Treatment Support Plan (2/4/08) 27. RSSLC Policy C.6: Ensuring Individual Rights (2/8/08) 28. RSSLC Policy C.7: Reviewing Restrictive Levels of Supervision (7/1/05) 29. RSSLC Policy C.16: Review of Rights Restrictions by the HRC (2/4/08) 30. PMAB Training Curriculum 31. Restraint Reduction Team Meeting minutes for 4/22/10 and 7/29/10 32. Restraint Checklist and Follow-up Form for Individual's #315 (9/10/10 4x), #212 (9/28/10), #140 (7/12/10), #160 (4/23/10), #448 (10/6/10 2x), #680 (10/5/10 2x), #174 (10/11/10), #325

	(8/24/10), #193 (8/29/10), #630 (9/11/10 3x), #58 (9/12/10) , #586 (9/13/10), and #309 (5/23/10) 33. Physician/Nurse Practitioner Assessment for Identifying Potential Health Risks for Restraint 34. Medical restraint documentation for individuals #112, #120, #440, #535, and #555. 35. Facility restraint log 4/1/10 to 10/25/10 36. List of individuals with a Safety Plan 10/27/10 37. List of individuals injured during restraint (January 1, 2010 to October 25, 2010). 38. Facility Restraint Analysis report for period ending 9/30/10 39. PSPs for Individual's #630, #58, #267, #315, #429, and #448 40. PSP Addendum's for Individuals #199, #630, #346, #267, #429, #740, #174, and #448 41. Annual Medical Summary individual #448 42. FY10 Trend Analysis 9/30/10 43. Incident Management Team minutes for 9/13/10, 9/20/10, 9/27/10, 10/4/10, 10/8/10, 10/11/10, 10/18/10, and 10/25/10 44. 45. List of individuals with medical or dental desensitization plans 46. List of individuals who received pre-treatment sedation for medical or dental procedures 47. Dental Support Plan documentation for Individuals #275, #429, #2, #144, #592, #44, #328, #256, #456, #455 48. Restraint Refresher Assessment Checklist 10/26/04 49. Direct Care Professional Training Records (20) 50. RSSLC Nursing Department's Presentation Book: Report Regarding Nursing's Role and Responsibilities Regarding Section C: Protection from Harm: Restraints 51. Parenteral Sedation Intravenous (IV) (TIVA) Anesthesia – Anesthesia Recover, Implemented: 6/1/10 52. RSSLC Behavior Intervention J.1, Use of restraints, Revised 9/1/09 53. RSSLC Behavior Intervention J.2, Using Restraint in a Behavior Emergency, Revised: 9/1/09 54. RSSLC Behavior Intervention J.3.01, Using Restraint in a Safety Plan – Contingent Restraint, Revised, 8/1/08 55. RSSLC Behavior Intervention J.3.02, Using Restraint in a Safety Plan – Protective Restraint, Revised 8/1/08 56. RSSLC Behavior Intervention J.4.01, Using Restraint During Medical/Dental Procedures, Revised: 8/1/08 57. RSSLC Behavior Intervention J.4.02, Using Restraint to Promote Healing/Recovery, Revised 8/1/08 58. RSSLC Behavior Intervention J.5, Using Restraint to Prevent Involuntary Self-Injury, 11/15/04 59. RSSLC Behavior Intervention J.6, Using Restraint to Provide Postural Support, Revised 11/15/04 60. RSSLC Unusual Incident Investigation Reports (for serious injuries since 5/1/10) 61. Reviewed Records for Individuals #140, #174, #57, #499, #285, and #415 **People Interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. Judy Miller, Settlement Agreement Coordinator 3. Reuben Muhammad, Incident Management Coordinator

	4. William Eckenroth, PhD, Director of Behavioral Services 5. Donald Paviska, Competency Training & Development Director 6. Carol Agu, QMRP Services Director 7. Charlene McCurry, RN, Chief Nurse Executive (CNE) 8. Kay Galloway, RN, Nurse Recruiter 9. Six Direct Care Professionals **Meetings Attended/Observations:** 1. Incident Management Team 10/25/10 2. Annual PSP for Individual #621 3. HRC meeting 10/28/10 4. Unit Morning Meetings at Rio Grande 10/27/10
	Facility Self-Assessment: The facility's self assessment reported the RSSLC was not in substantial compliance with any provision or component of this section of the settlement agreement (SA). The monitoring team's review substantiates this self assessment and determined that the RSSLC had demonstrated very little progress in addressing issues identified in the baseline report. For example, the baseline report recommended RSSLC restraint policies be rewritten to be clearer, more instructive to staff, and to ensure alignment with DADS policy and the provisions of the SA. The draft policy revisions given to the monitoring team during the review only reflected a few minor changes and did not address more fundamental discrepancies between the RSSLC policies on restraint and the State policy issued by DADS. The DADS policy was written to ensure State Supported Living Centers (SSLCs) can comply with the SA by adhering to the DADS policy.
	Summary of Monitor's Assessment: The RSSLC policies that govern restraint were not in alignment with DADS policy on restraint. As a result, implementation of RSSLC restraint policies will not ensure compliance with the SA. DADS policy on restraint addresses the requirements of the SA and it will be important to the RSSLC that its policies reflect DADS policy in order to achieve SA compliance. This incongruity was most notable in some of the basic terms used in the SA compared with terminology in RSSLC policy. For example, the SA, and DADS policy, defines four types of acceptable restraint (chemical, mechanical, medical, and physical). The RSSLC policies define nine types of acceptable restraint (chemical, contingent, emergency, medical, mechanical, mechanical restraint to promote healing, physical personal restraint, protective restraint, and restraint to promote healing). Some of the categories of restraint in RSSLC policies may be a subset of the four types of restraint described in DADS policy; however, the written RSSLC policies can lead to confusion and misunderstanding when applied to SA provisions as definitions did not always match and staff explaining policy implementation were sometimes unable to do so in the context of SA requirements. There are also significant elements of the DADS policy which the RSSLC did not follow. For example, RSSLC did not use the DADS-required Face-to-Face Assessment/Debriefing form to assess the circumstances of each restraint. DADS policy requires that a Safety Plan be developed for any individual who was restrained 4 or more times in a rolling 30 day period. The RSSLC had nine individuals who met these criteria. None

	had a Safety Plan. RSSLC employees were, for the most, part current in restraint related training. Review of the documentation relating to all form of restraint usage indicated that nurses did monitor individuals who were restrained but failed to consistently notify the physicians prior to use of chemical restraint or inform the physician of assessment findings when notifying the physician of chemical restraint use or notify the physician when the individual's blood pressure dropped below baseline after receiving psychoactive medication. The completed Medical Monitoring of an Episode of Acute Illness/Sedation Forms were not consistently placed in individuals' primary records but were retained in the Nurse Case Manager's files.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	The RSSLC POI reported noncompliance with this provision of the SA. The monitoring team concurs. DADS Policy 001 – Use of Restraints prohibits the use of prone restraint. This policy also addresses the other elements required by the Settlement Agreement (SA). RSSLC Policy J.1 Use of Restraint in the Definitions section states a prohibition of the use of prone restraint. This prohibition was stated clearly in the Procedures section of the policy at 4.d. The monitoring team did not discover any evidence of the use of prone restraint. Staff interviews also confirmed understanding of this prohibition. RSSLC had a comprehensive set of policies defining and governing use of restraints. These included, in addition to J.1, J.2 Using Restraint in a Behavioral Emergency, J.3.01 Using Restraint in a Safety Plan – Contingent Restraint, J.3.02 Using Restraint in a Safety Plan – Protective Restraint, J.4.01 Using Restraint during Medical/Dental Procedures, J.4.02 Using Restraint to Promote Healing/Recovery, J.5 Using Restraint to Prevent Involuntary Self-Injury, and, J.6 Using Restraint to Provide Postural Support. These policies did not always define restraint consistent with the definitions in the SA and in DADS policy. They also did not always include some of the specific requirements of the DADS policy. For example, RSSLC did not use the DADS required Face-to-Face Assessment/Debriefing form to assess the circumstances of each restraint. DADS policy requires that a Safety Plan be developed for any individual who was restrained 4 or more times in a rolling 30 day period. The RSSLC had nine individuals who met these criteria. None had a Safety Plan. The RSSLC had not at the time of the review fully implemented the revised Restraint Checklist issued as a policy revision by DADS in June. Twelve of 18 Restraint Checklists reviewed used the old form which did not include comprehensive descriptors in the sections describing interventions attempted prior to restraint, method of restraint, event	N

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		codes, and action/release codes. While restraints appeared to be used when a condition of immediate harm to the individual or some one else was present, it was not clear if restraint should have become the necessary outcome of each specific situation. For example, the monitoring team's review of a sample of restraint checklists indicated the circumstances immediately preceding restraint included "hit staff in the head with the phone" (Individual #325) which resulted in a horizontal restraint lasting 16 minutes, "threw a bowl of cereal almost hitting a client" (Individual #193) which resulted in a horizontal restraint lasting 7 minutes, "kicked staff" (Individual #630)which resulted in a personal hold lasting 13 minutes, and "hit staff with a spoon and grabbed staffs (sic) nametag" (Individual #58) which resulted in a bear hug/baskethold/horizontal restraint lasting 4 minutes. In each instance the interventions attempted prior to restraint included primarily verbal and physical redirection. Because these restraints were documented on the old Restraint Checklist (even though they occurred between 8/24/10 and 9/12/10 – well after the new Restraint Checklist was to be used) there were limited intervention options to consider and document. The new Restraint Checklist added intervention options that could document "prompted replacement behavior," "prompted coping skills," "interventions in PBSP," "interventions in safety plan," "PMAB protection skills," "removed dangerous object," "moved others away," "traded out staff," "moved furniture," and "treatment w/o restraint." Because of the limited information on the Restraint Checklist and accompanying Restraint Follow-up form, the monitoring team was not able to validate that restraint was always used after a graduated range of less restrictive measures had been attempted. It was difficult to assess whether restraint use was conducted in a clinically justifiable manner, for reasons other than the convenience of staff, or in the absence of or as an alternative to treatment. Practice deficiencies described in Section J Psychiatry, Section K Psychology, Section L Medical, and Section S Habilitation all contribute to a lack of effective program planning and implementation that can result in behavioral manifestations that staff address through the use of restraint rather than effective less restrictive techniques. • Zero of 17 (0%) of records in the sample included a formal functional assessment process that would meet accepted standards of applied behavior analysis. None of these assessments produced a specific statement or hypothesis of function. Without formal functional assessment, it is not probable that an effective behavior intervention can be developed, especially when a behavior is dangerous enough to require restraints regularly and over months or years without effective behavioral	

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		treatment. • Most (nine of10) proposed psychiatric treatment plans focused largely or exclusively on the reduction of the individual's aggressive and self injurious behaviors. Appropriate use of psychotropic medication use should be linked to relevant behavioral symptoms of specific psychiatric diagnoses. In turn, proper identification of those symptoms would provide guidance as to the appropriate choice of medication. • There were examples in which there was no consideration of the possible contribution of underlying health care issues that result in pain and/or discomfort extreme behaviors to extreme behaviors that may result in use of restraint. Restraint use at the RSSLC was governed by policy although as noted the policies were not congruent with State policy intended to assure SA compliance and were therefore inadequate. The monitoring team did not discover any instances of restraint use that was not approved in the Facility's policies.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The RSSLC POI reported noncompliance with this provision of the SA, and the monitoring team concurs. DADS policy J.1 SectionII.I.1 states "the individual must be released from restraint as soon as he or she no longer poses an immediate and serious risk of harm to him/herself or others. If there is a Safety Plan, the individual will be released according to the instructions that are stated in the Safety Plan (indicators when the individual no longer poses an immediate and serious risk of harm)." RSSLC Policy J.1 Procedures 4.n requires that "individuals must be released from restraint when the individual is no longer dangerous to self or others." Policy J.2 Using Restraint in a Behavioral Emergency Step 5 (page 2) describes release criterion as being when the person is calm without regard to any specific behavior which the restraint was intended to abate. An individual may not be calm but may not exhibit dangerous behavior. For example, yelling, cursing, crying, and/or screaming but not being aggressive to self or others might not indicate continued dangerousness for an individual. Being calm should not be a sole criterion for restraint release. Without behaviorally related release criteria,it is possible an individual may be kept in restraint longer than necessary. In order to adequately protect the individual, the Facility should explicitly define release criteria based upon the characteristics of each unique individual. In the baseline review the monitoring team pointed out that in a limited review of Restraint Checklists the release from restraint code used most often was number 8 which	N

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		is the code for calm. This was still prevalent in the review of restraint documentation during the first compliance review. For example, the Restraint Checklist for Individuals #58, #630, #325, and #193, each indicated release from restraint occurred when the individual was quiet/calm. Two additional Restraint Checklists, both for Individual #315 did not contain any code so it was impossible to determine the individuals' status at the time of restraint release.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The RSSLC POI reported noncompliance with this provision of the SA and the monitoring team concurs. RSSLC had a comprehensive set of policies defining and governing use of restraints. These included J.1 Use of Restraint, J.2 Using Restraint in a Behavioral Emergency, J.3.01 Using Restraint in a Safety Plan – Contingent Restraint, J.3.02 Using Restraint in a Safety Plan – Protective Restraint, J.4.01 Using Restraint during Medical/Dental Procedures, J.4.02 Using Restraint to Promote Healing/Recovery, J.5 Using Restraint to Prevent Involuntary Self-Injury, and, J.6 Using Restraint to Provide Postural Support. These policies did not always define restraint consistent with the definitions in the SA and in DADS policy. They also did not always include some of the specific requirements of the DADS policy. For example, RSSLC did not include in its policy the use of the DADS required Face-to-Face Assessment/Debriefing form to assess the circumstances of each restraint. DADS policy requires that a Safety Plan be developed for any individual who was restrained 4 or more times in a rolling 30 day period. RSSLC policy did not include this important requirement and in fact the 9 individuals that met these criteria did not have a safety plan. RSSLC should revise its restraint policies to ensure they are congruent with DADS restraint policy and all elements of the SA. RSSLC would be well served to consolidate its current policies into one comprehensive facility restraint policy as well. The monitoring team was not able to validate that restraint was only used as the "least restrictive intervention necessary to manage behaviors." Practice deficiencies described in Section J Psychiatry, Section K Psychology, and Section S Habilitation all contribute to a lack of effective program planning and implementation that can result in behavioral manifestations that staff address through the use of restraint rather than effective less restrictive techniques. RSSLC employees were, for the most, part current in restraint related training. Data reports indicate 97% of employees were current with PMAB 4 – Restraint Training, 98% were current with RES0105 – Restraint: Prevention and Rules for Use, and, 99% were current with RES0110 – Applying Restraint Devices. These three classes included curriculum that addresses verbal intervention and redirection techniques, approved	N

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		restraint techniques, and responsibilities for supervision of those in restraint. In addition, a review of a sample of staff training records indicated all employees in the sample were current with all three restraint related classes. The monitoring team is concerned about the effectiveness of this training and the degree to which it is competency based. The examples of documentation mistakes noted in Section C suggest improvement is needed. In the baseline review the monitoring team pointed out that there was not standardized training for the use of mechanical restraints. This was still the case. In response to a document request for training curriculum used in initial and refresher training on the use of mechanical restraint, the monitors were provided with a Restraint Refresher Checklist with material supplied by the restraint manufacturer attached. Staff indicated there was no formal curriculum. When asked for a list of staff who provide training in the use of mechanical restraint, the monitoring team was provided with a list of all staff in the psychology department. RSSLC needs to have a more standardized approach to training staff in the use of mechanical restraints.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	The RSSLC POI reported noncompliance with this provision of the SA and the monitoring team concurs. RSSLC Policy J.1 lists six circumstances under which restraint will be used. Two are described as crisis intervention, two as related to medical/dental procedures or recovery, one related to self-injurious behavior, and one related to postural support. In the baseline review the monitoring team noted that under the right circumstances each use may be appropriate, although the policy clarifications described in C1 and language changes related to clearer delineation of what constitutes a medical restraint were needed. This was still the case. There is also a concern as to whether or not restraint use was limited to crisis intervention. While restraints appeared to be used when a condition of immediate harm to the individual or some one else was present and crisis intervention would ordinarily be called for, it was not clear if restraint should have become the necessary outcome of each specific situation. For example, the monitoring team's review of a sample of restraint checklists indicated the circumstances immediately preceding restraint included "hit staff in the head with the phone" (Individual #325) which resulted in a horizontal restraint lasting 16 minutes, "threw a bowl of cereal almost hitting a client" (Individual #193) which resulted in a horizontal restraint lasting 7 minutes, "kicked staff" (Individual #630)which resulted in a personal hold lasting13 minutes, and "hit staff with her spoon	N

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		and grabbed staffs nametag" (Individual #58) which resulted in a bear hug/basket hold/horizontal restraint lasting 4 minutes. In each instance the interventions attempted prior to restraint included primarily verbal and physical redirection, apparently unsuccessfully. Because these restraints were documented on the old Restraint Checklist (even though they occurred between 8/24/10 and 9/12/10 – well after the new Restraint Checklist was to be used) there were limited intervention options to consider. The new Restraint Checklist added intervention options that could document "prompted replacement behavior", "prompted coping skills", "interventions in PBSP", "interventions in safety plan", "PMAB protection skills", "removed dangerous object", "moved others away", "traded out staff", "moved furniture", and "treatment w/o restraint". Because of the limited information on the Restraint Checklist, and accompanying Restraint Follow-up form, the monitoring team was not able to determine with certainty that restraint was the necessary intervention to address the actual, or perceived, crisis or that a graduated range of less restrictive measures had been attempted that may have averted the crisis that resulted in restraint.. Additionally, practice deficiencies described in Section J Psychiatry, Section K Psychology, Section L Medical and Section S Habilitation all contributed to a lack of effective program planning and implementation that can result in behavioral manifestations that staff address through the use of restraint rather than effective less restrictive techniques. On Page 7 of J.1 there is a description of an Individual Risk Assessment that would address the SA requirement that no restraint be used that is prohibited by medical orders or the individuals PSP. RSSLC used a form entitled "Physician/Nurse Practitioner Assessment for Identifying Potential Health Risks for Restraint." The monitoring team reviewed this documentation for the nine most frequently restrained individuals. These forms typically identified risk factors by checking categorical descriptors such as "severely ill individual" or "bleeding tendency with minor trauma" but in only one instance did the form signed by the physician/Advanced Practice Registered Nurse provide specific guidance or instruction to the PSP team as to how the checked descriptor would affect restraint use. In this one case the physician noted "do not press on chest. No baskethold or bear hug." Without guidance or directions from the physician completing this form its purpose appears to be, in most cases, a perfunctory administrative task that does not address the intent of the SA. RSSLC Policy J.11 using Sedation for Medical/Dental Appointments requires the Personal Support Team (PST) to consider five general questions that address considerations other than restraint. These include: what are the frequency and possible causes of behaviors that interfere with the individual's ability to receive routine medical/dental treatment, what does staff do to prepare the individual for medical or dental examinations in order to	

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		reduce the need for sedation, and similar questions. This policy refers to Policy J.13 Implementing Dental Support Treatment Support Plan. In a review of implementation of Policy J.13 the monitoring team determined that the Dental Treatment Support Plan Checklist (DSP) called for in the policy was, for the most part, not being used by PSTs. This checklist was characterized in the policy as "the form that is used to develop an individualized approach to increase toleration for dental procedures by selecting applicable methods from the following" followed by descriptions of ten possible strategies. Most documents presented to the monitoring team as dental support plans did not meet the requirements of policy J.13. Most were limited to tooth brush tolerance programs. As indicated in Provision J4, some DSPs did contain a task analysis and training or desensitization program. From document review there did not appear to be any standardized, policy directed, methodology for the development of medical support plans to address use of pretreatment sedation.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed	The RSSLC POI reported noncompliance with this provision of the SA and the monitoring team concurs. RSSLC Policy J.1 Use of Restraints requires a face to face assessment by a restraint monitor no later than 15 minutes after the restraint is implemented and an assessment by a licensed health care professional at least every thirty minutes from the start of the restraint. The facility did not document the face-to-face assessment required by facility policy on the state mandated form entitled "Face-to-Face Assessment/Debriefing and Reviews for Crisis Intervention Restraint." The facility used a form entitled "Emergency/Contingent Restraint Debriefing." The RSSLC form contained 29 expected data items. The DADS form contains 47 expected data items and more if the restraint is a chemical restraint. Not all data expected by DADS policy was collected, recorded, and available for use in reviewing the application and consequences of each specific use of restraint. Because of this, restraint analysis at RSSLC cannot be as comprehensive as contemplated by DADS policy which is intended to ensure a level of analysis sufficient to comply with the SA. Review of the documentation relating to all form of restraint usage indicated that nurses did monitor individuals who were restrained but failed to consistently notify the physicians prior to use of chemical restraint or inform the physician of assessment findings when notifying the physician of chemical restraint use or notify the physician when the individual's blood pressure dropped below baseline after receiving psychoactive medication. The completed Medical Monitoring of an Episode of Acute Illness/Sedation Forms were not consistently placed in individuals' primary records but were retained in the Nurse Case Manager's files.	N

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	health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	• Review of individual #140's Integrated Progress Notes indicated that on 7/12/10 at 11:50 a.m., the staff nurse notified the physician of individual #140's behavior and received an order for Zyprexa 10 mg. Zyprexa 10 mg was administered orally at 12:03 p.m. for agitation. Individual #140 was placed on 1:1 supervision by the Qualified Mental Retardation Professional (QMRP). Medical Monitoring was initiated at 12:15 p.m., 2:00 p.m., 5:00 p.m., 9:00 p.m., 11:30 p.m., and on 7/13/10 at 3:00 a.m. Individual #140's vital signs remained stable throughout the medical monitoring without reported side effects or adverse reaction or injury sustained reported secondary to receiving Zyprexa. However, the individual remained uncooperative and pacing until going to sleep at 3:00 a.m. on 7/13/10. The Integrated Progress Notes written by the staff nurse failed to document a complete assessment including a description of individual #140's behavior when notifying the physician. Nor did the documentation include precipitating factors that might have contributed to the maladaptive behavior or attempts of less restrictive measures before notifying the physician and obtaining an order for Zyprexa. It was positive that the Integrated Progress Notes were written in the SOAPE format. If a Restraint Checklist was completed, it was not made available for review. The Nursing Department needs to ensure that nurses complete and document an assessment of individuals' health status, description of maladaptive behaviors, possible contributing factors contributing to maladaptive behaviors, and attempts of less restrictive measures implemented when notifying physicians' for order for emergency medical (chemical) restraints. • Review of individual #415's Integrated Progress Notes written by the staff nurse on 10/9/10 (misdated--should have been 10/8/10 when cross-walked with the 10/8/10 Restraint Checklist) at 9:00 p.m. stated that the direct care professional staff reported that the individual had not slept "today". Vital signs were reported. The nurse assessed individual #415 as having insomnia. Per physician's order Ambien 10 mg was administered orally at 9:00 p.m. The campus coordinator was notified and the chemical restraint protocol was initiated at 9:00 p.m. At 9:15 p.m. vital signs were reported. At 9:30 p.m. individual #415 was reported as sleeping and snoring loudly, skin diaphoretic capillary refill less than two seconds. Vital signs were reported. Individual was placed in Trendelenburg position for hypotension. The drop in blood pressure from the baseline at 9:00 p.m. of 119/70 to 70/40 represented a decrease of 49 millimeters of mercury (mmHg) in systolic pressure and a decrease of 30 mmHg in diastolic pressure with diaphoresis was a significant drop in blood pressure. There was no documentation that the physician was notified of the sudden drop in blood pressure 30 minutes after the administration of Ambien. The sudden drop in blood pressure with diaphoresis could have indicated an adverse side effect to the	

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		Ambien. The next Integrated Progress Note written by the nurse after the change of shift was at 10:15 p.m. with the vital signs reported as "within normal range" and to refer to the Vital Sign Chart. Fortunately individual #415's blood pressure began to return to baseline. However, this does not negate the need for the nurse to report sudden drops in blood pressure to the physician particularly after taking a psychoactive medication such as Ambien. Review of individual #415's Restraint Checklist was initiated, according to Facility Policy (the revised State Policy and Form was not used) on 10/9/10 at 9:00 p.m. The location was in the Infirmary. The description of events leading to restraint use was listed as insomnia. Interventions attempted to avoid restraint was listed as "not applicable". The method of restraint was listed as chemical, e.g., Ambien 10 mg orally. The reason given for the chemical restraint was insomnia. The physician was contacted on 10/8/10 at 12:20 a.m., which was more than three hours after the Ambien was administered. According to the Integrated Progress Notes Ambien 10 mg was administered at 9:00 p.m. The physician should have been notified prior to administering Ambien. No event codes were entered for the chemical restraint. The Shift Change Review was completed by the off going and on coming nurses. Individual #415's physical, emotional, and behavioral condition was reported as asleep and hypotensive. Medications administered during the restraint usage included Ambien 10 mg orally at 9:00 p.m. In the RN/LVN Restraint Physical/Mental Evaluation Section it was evident individual #415 was monitored at least every 15 minutes between 9:00 p.m. and 10:45: p.m. The post restraint Assessment was not timed but individual was apparently released from monitoring at 10:45 p.m. and was reported alert, awake, with no distress noted After review of individual #415's integrated Progress Notes and Restraint Checklist, several significant concerns were raised: Ambien administered at 9:00 p.m. without other measures for sleep tried before administering a hypnotic. Physician was not notified immediately when individual #415's blood pressure dropped significantly within 30 minutes after receiving Ambien coupled with reported diaphoresis. This could have been indicative of an adverse side effect to the Ambien and the physician should have been made aware, even though the blood pressure did return to baseline within about an hour. The physician was not notified for the administration of Ambien until 12:20 a.m. when the medication was administered at 9:00 p.m. The physician should have been notified prior to administering the Ambien. The Nursing Department needs to ensure that physicians are notified immediately when an individual's blood pressure drops significantly below baseline after the administration of	

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		medications, particularly psychoactive medications. The Nursing Department needs to ensure that physicians' are notified prior to the administration of chemical restraints. The RSSLC policy did not specifically address restraint episodes that occur away from the facility. None were noted in the restraint log presented to the monitoring team. There was reference to "coordination" but the policy lacks specificity that addresses administrative or clinical requirements for restraint that would occur away from the facility. Policy J.2 Using Restraint in a Behavioral Emergency contains the same requirements for restraint monitoring as J.1. Policy J.3 Using Restraint in a Safety Plan – Contingent Restraint does not contain the explicit requirements in J.1 related to restraint monitoring. J.3 does not explicitly require a face to face assessment. Instead the language reads "monitor the individual to the extent necessary to ensure the individual's safety." It does not specify who was to monitor and the policy makes no reference to a restraint monitor. J.3 requires that a nurse check the person for injuries within 30 minutes of release but does not require a licensed health care professional documentation of vital signs and mental status at least every 30 minutes. This was an example of how consolidating RSSLC restraint policies into one comprehensive document with consistent terminology and requirements, where appropriate, would likely facilitate more uniform practices that would comply with SA provisions. Policy J.4.01 Using Restraint during Medical/Dental Procedures does not call for the physician to specify the schedule and type of monitoring required. There is a requirement that the physician order must include "special instructions for the individual's care, if any, while in restraint and following restraint." This was overly vague in light of the specificity called for in the SA. The monitoring team reviewed five individuals who received medical restraint (pre-treatment sedation). Only one of the five had a completed "Medical Monitoring for Sedation" form included in the documentation submitted to the monitoring team. This was the form used to specify the schedule and type of monitoring required in each instance of medical restraint. Policy issues aside, the monitoring team noted multiple examples of practices not in compliance with the SA. For example, Individual #315 was restrained on 9/10/10. The Restraint Checklist indicated the restraint monitor was notified at 3:45pm when the restraint did not occur until 4:00pm. The restraint monitor was also listed as the person who applied the restraint (mechanical). Individual #630 was restrained on 9/11/01 at	

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		2:35pm. The Restraint Checklist did not indicate the monitor was ever called. The post restraint physical evaluation occurred at 3:35pm, one hour after the restraint episode ended. Individual #448 was restrained on 10/6/10 at 2:05pm. The Restraint Checklist indicated the restraint monitor was called at 2:26pm, after the 15 minute requirement. The first nursing assessment was documented as occurring at 2:45pm, after the 30 minute requirement.	
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 RSSLC POI reported noncompliance with this provision of the SA and the monitoring team concurs. RSSLC Policy J.1 Monitoring section does not explicitly require that an individual be checked for restraint related injury. Policy J.1 does not require the completion of a Restraint Checklist which is required by the State and is where an injury check is documented. Policy J.2 (Behavioral Restraint) and J.3 (Contingent Restraint) do require use of the Restraint Checklist. In practice RSSLC does use the Restraint Checklist as required by the State although in most instances they were not using the most current version of the Restraint Checklist and therefore were not capturing all relevant data. Policy J.1 monitoring section does not explicitly require opportunities for exercise, fluids, or use of the toilet except for instances of protective restraint. Policy J.2 does not address this at all. Policy J3 does include this provision. Policy J.4.01 (Medical/Dental) does not explicitly reference enhanced supervision, only a reference to "staff must evaluate the individual periodically." This was too vague to guide staff conduct. Policy J.1 (page 8) requires 1:1 staff supervision when an individual is in emergency or contingent restraint. The above observations made by the monitoring team demonstrate the previously stated need for a comprehensive overhaul of restraint policy at the RSSLC to ensure every element of the DADS restraint policy, and of the SA, are addressed. The Restraint Checklist includes Action Codes related to motion/exercise, toileting, meal offered, and fluid offered, Most of the restraints reviewed were of short duration where one would not expect to see these codes used. Most Restraint Checklists and medical restraint documentation reviewed by the monitoring team did not indicate what level of supervision the restrained individual was on. The Restraint Checklist for Individual #448 (horizontal side-lying restraint 10/6/10)	N

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		indicated enhanced supervision, not one-to-one as required. As the above examples show, restraint use was not documented consistent with Appendix A of the SA.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	The RSSLC POI reported noncompliance with this provision of the SA and the monitoring team concurs. The monitoring team identified nine individuals who met the criteria for this provision. These were Individuals #346, #315, #448, #174, #740, #429, #199, #267, and #328. None of these individuals had a safety plan as required by DADS policy and none had a sufficient review by the individual's treatment team to address the substance of this provision of the SA. RSSLC Policy J.1 (page 12) contains the following: "The Unit Team Meeting will include tracking of restraint use by individual to notify the QMRP of the need to conduct a PST review for any person who had more than 2 emergency or contingent restraints within any rolling 30 day period. The PST review must consider the accuracy of treatment plan implementation; environmental factors including scheduling issues; personal factors including diagnostic characteristics, medical problems, psychosocial issues; skill deficits and need for additional skill training (e.g. additional SPOs or a PBS); and risk management including need for a Safety Plan." This contains some, but not all review elements required by the SA. This once again points out the need for a restraint policy overhaul by the RSSLC. RSSLC produced documentation to demonstrate PSP review of individuals who met the criteria for four or more restraints in a rolling 30 day period. Some of the documentation consisted of a PSP Addendum (which was described in interview as the appropriate documentation) but only for 5 of the 9 individuals. Information was not thorough or comprehensive. For example, for Individual #346 the review of the Behavior Support Plan (BSP) consisted of "individual is on a BSP. Targeting aggression." For Individual #630 the review of adaptive skills, biological, medical, and psychological factors consisted of "functioning with the moderate range of intellectual functioning and the severe range of adaptive functioning." This was inadequate to meet the requirements of the SA and appears to be a perfunctory administrative activity rather than a thoughtful clinical review of sufficient scope and depth to potentially reduce restraint utilization.	N
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	Structural and functional assessments were not adequate to identify function or to establish clear hypotheses about functional versus medical and psychiatric factors. Additionally, records reflected that functional assessments were typically conducted on an	N

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		annual basis rather than upon need or changes in behavior. • For Individual #770, although screenings for behavior function were completed, a thorough functional assessment was not completed and direct observations were not documented with data. Behavioral Services Department staff stated that assessments of adaptive skills were not conducted at the Facility. As a result, formal adaptive skill assessments were not available for identifying strategies to minimize use of restraint.	
	(b) review possibly contributing environmental conditions;	Data and other information about environment relevant to possible contribution of environmental conditions were not collected in enough detail to determine the cause of behavior provoking restraint, nor were environmental conditions changed in response to such information. Refer to Section K for recommendations regarding functional assessments of behavior.	N
	(c) review or perform structural assessments of the behavior provoking restraints;	Data were not collected in enough detail to determine the cause of behavior provoking restraint. Although descriptive assessments were often completed, they were highly subjective and not supported by comprehensive functional assessment or data from formal direct observations. Refer to Section K for additional information about behavior assessment and recommendations regarding functional assessments of behavior.	N
	(d) review or perform functional assessments of the behavior provoking restraints;	Functional assessments typically did not reflect the use of true functional assessments or direct observation data, and did not produce specific hypotheses about the function of the undesired behavior or potential replacement behaviors. As a result, it was generally not possible to determine the cause of behavior provoking restraint, nor were the assessments repeated when interventions were not effective in reducing use of restraints. See section K for recommendations regarding functional assessments of behavior.	N
	(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,	Data were not collected in enough detail to determine the cause of behavior provoking restraint. Therefore, PBSPs and PBSP addendums that actually were developed in response to restraint use were not based on adequate assessment, and restraint data did not indicate that these changes were effective in reducing use of restraint. See section K for recommendations regarding functional assessments of behavior.	N

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	where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;		
	(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	Sampled PSP Addendums would recommend BSP changes in some cases. Refer to Section K for discussion and recommendations regarding deficient practices in BSP planning.	N
	(g) as necessary, assess and revise the PBSP.	It did not appear that consistent data were being collected with respect to behavioral incidents and interventions. Because of this the appropriateness of treatments and supports was questionable. In many cases reviewed, the individual went on to have additional episodes of restraint, suggesting whatever actions were taken as a result of the PSP Addendum meeting were ineffective. Refer also to section K.	N
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 RSSLC POI reported noncompliance with this provision of the SA and the monitoring team concurs. RSSLC Policy J.1 (page 12- 10.d) requires a review of each episode of restraint within 3 working days by the Unit Team and the Incident Management Team. Section 10. e of that policy requires that Behavioral Services conduct a review of each instance of restraint and write up recommendations for the PST to complete a PSP Addendum to address all restraint follow-up recommendations. This seems to be part of the 3 day review process but because of the way the paragraphs were organized in Section 10 it was not altogether clear. As referenced in C1, C3, C4, C5, and C6, RSSLC needs to engage in a comprehensive review of its restraint related policies to ensure they meet the requirements of DADS policy and the SA and are instructive to staff who must carry them out. The policy needs to be written and organized so that it is clear, consistent, and unambiguous.	N

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		Through interview and observation it was apparent restraint review was a topic in each unit morning meeting and in the facility-wide Incident Management daily meeting. Staff participating in these meetings did not have specific documents (e.g. Restraint Checklist, Face-to-Face Assessment, etc.) available to them to use in the review process. Rather, they relied on a verbal representation of events, usually provided by a psychology staff member or an administrative staff person. This appears to the monitoring team to be more of a perfunctory administrative process rather than a substantive review to ascertain the circumstances under which restraint was used presumably to identify clinical, habilitation, and medical issues that may need to be addressed to prevent future use of restraint.	

Recommendations:

1. Review all restraint related policies – establish a standardized format, update and/or consolidate various policies, and align each policy with DADS policy and the elements of the Settlement Agreement.
2. Develop a standardized curriculum and methodology for training of staff in the use of mechanical restraints.
3. In order to adequately protect the individual, the Facility should explicitly define release criteria based upon the characteristics of each unique individual.
4. The Nursing Department needs to ensure that physicians' are notified prior to the administration of chemical restraints and that nurses complete and document an assessment of individuals' health status, description of maladaptive behaviors, possible contributing factors contributing to maladaptive behaviors, and attempts of less restrictive measures implemented when notifying physicians' for order for emergency medical (chemical) restraints.
5. Develop a quality assurance process for restraint documentation.
6. Ensure when restraint use is included on the Client Incident Report that the length of time the individual was kept in restraint is documented on the report.
7. Generally improve behavior support services (see section K) so that restraint is used in a clinically justifiable manner.
8. Substantively improve the work processes necessary to achieve compliance with the SA requirements associated with individuals being restrained 3+ times in a rolling 30 day period.
9. Review the definition of physical restraint in the SA and assess the use of each individual use of a mechanical device, such as belts, mittens, and wrist and anklets supports, to ensure proper restraint and review procedures are followed if their use constitutes a physical or mechanical, rather than medical, restraint.
10. Substantively improve the work processes necessary to properly implement policies associated with medical restraint (medical and dental pre-treatment sedation).
11. Ensure all restraint monitors are competency based trained and develop a mechanism to validate ongoing competency.
12. The Nursing Department needs to ensure that physicians' are notified immediately when an individuals' blood pressures drops significantly below baseline after the administration of medications, particularly psychoactive medications.
13. Develop mechanisms to ensure review of individual restraint episodes have sufficient clinical orientation.
14. If the Unit Meetings and IMRT meetings continue to be the "official" mechanism to achieve the 3 day review required by the SA, modify practice to ensure committee members have relevant documents to review.

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:** 1. DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 6/18/10. 2. DADS Policy 02.2 Incident Management 6/18/10. 3. DADS Policy 01 Use of Restraint dated 8/31/09. 4. RSSLC Plan of Improvement (POI) 5/17/10 5. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10 6. RSSLC Policy A.17: Managing Unusual Incidents (6/30/10) 7. RSSLC Policy A.25: Securing Evidence (7/17/09) 8. RSSLC Policy B.15: Taking Disciplinary Action Following Confirmed Abuse, Neglect, or Exploitation (8/1/07) 9. RSSLC Policy B.26 Placing an Employee on Investigative Leave (6/30/10) 10. RSSLC Policy C.1: Reporting Abuse, Neglect, Exploitation (6/30/10) 11. RSSLC Policy C.2: Actions Following Report of Abuse, Neglect, Exploitation (6/30/10) 12. RSSLC Policy C.3: Action Following Investigation of Abuse, Neglect, Exploitation (6/30/10) 13. RSSLC Policy C.5: Initial Actions Regarding Sexual Abuse, Neglect and Exploitation, and Other Sexual Incidents (12/30/02) 14. RSSLC Policy C.12: Reporting Incidents to DADS Regulatory (1/23/03) 15. RSSLC Policy D.8: Completing/Routing Client Injury Report (3/16/09) 16. RSSLC Policy D.13: Conducting an Addendum Meeting for Repeated Injuries (5/1/09) 17. RSSLC Policy D.20 Conducting an Interim Meeting for a Serious Injury (7/14/03) 18. RSSLC Policy E.17 Completing Incident Information Reports (2/28/08) 19. RSSLC Policy J.9: Conducting Interim for Repeat Incidents of Aggression (11/7/03) 20. PMAB Training Curriculum 21. Incident Management Meeting minutes for 9/13/10, 9/20/10, 9/27/10, 10/4/10, 10/8/10, 10/11/10, 10/18/10, and 10/25/10 22. Individual Training Records and personnel documentation for RSSLC Investigators 23. Individual Training Records and personnel documentation for DFPS Investigators 24. Sample documentation of volunteer background checks 25. Sample documentation of employee background checks 26. RSSLC Criminal Background Checks report 10/21/10 (employees and volunteers) 27. Training curriculum for Abuse, Neglect, and Exploitation 28. Acknowledgement of Reporting signed forms for 20 randomly selected employees 29. Abuse and Neglect Allegations log 4/1/10 – 10/1/10 30. DFPS Investigation Reports 36998349, 38279347, 37024029, 37030149, 37199349, 37239780, 37240220, 37303300, 37325560, 37378880, 37528525, 37764980, 37791960, 37837262, 37847762, 38081741, 36797734, 36785811, 36659430, 36536934, 37199349, 36895571, and 36552109

	31. Personnel action documentation for sample of employees 32. Peer Caused Injury log since 1/1/10 33. Incident and Injury Log 5/1/10 -10/25/10 34. Incident Information Report (E.17) for Individual #529 and #597 35. Log of injuries where an Individual caused injuries to other individuals 1/1/10 -10/1/10 36. UIRs 10-089, 10-098, 10-101, 10-105, 10-110, 10-111, 10-121, 10-122, 10-124, 10-125, 10-129, 10-129, 10-132, 10-133, 10-134, 10-135, 10-136, 10-138, 11-003, 11-005, 11-008, 11-010, 11-011, 11-021, 11-027, 11-028, and 11-032 37. Client Injury Reports for Individuals #424 (9/15/10), #100 (9/15/10), and #316 (8/24/10) 38. PSP and BSP for Individuals #424, #100, and #316 39. Top 10 Injured Individuals 1/1/10 – 10/25/10 and data summaries on each individual 40. Staff Training Records (20) 41. Self Advocate meeting minutes 6/30/10, 7/21/10, 8/25/10, and 9/22/10 42. 2010 RSSLC Survey of Employee Engagement **People interviewed:** 1. Al Barrera, Facility Director 2. Jane Purcell, Assistant Director of Programs 3. Joan Poenitzsch, Director of Quality Assurance 4. Judy Miller, Settlement Agreement Coordinator 5. Reuben Muhammad, Incident Management Coordinator 6. John Kimble, OIG Investigator 7. Donald Paviska, Competency Training & Development Director 8. Carol Agu, QMRP Services Director 9. Richard Rodriquez, Detective, Ft. Bend County Sheriffs Department 10. Six Direct Care Professionals **Meetings attended/Observations:** 1. Incident Management Team 10/25/10 2. HRC meeting 10/28/10 3. 10/27/10 Unit Morning Meetings at Richmond
	Facility Self-Assessment: RSSLC reported in the POI substantial compliance with provision D.5 of the SA. The monitoring team concurs. All other provisions of Section D were self assessed as not in compliance. The monitoring team determined that provision D.1 is also in substantial compliance. The monitoring team identified 9 components of a provision that were also in substantial compliance. The RSSLC POI correctly identified several areas of concern that were validated during the review. The RSSLC is to be commended for its work to date in moving towards compliance in Section D.
	Summary of Monitor's Assessment:

	RSSLC had a well organized system for reporting and investigating allegations of abuse and neglect, investigating unusual incidents, and reviewing discovered injuries. This system included the necessary incident management components to review reports, determine necessary follow-up, and track action plans through completion. The policies that guide these processes were comprehensive and appear, for the most part, to be achieving the desired results. Some issues of potential significance were identified in the areas of timely reporting of incidents, timely investigations, and protection of individuals, including the following: • Review of documentation of reporting identified several incidents of late reporting. • Some DFPS investigations were not initiated and/or completed within policy and SA-required timelines. • The competency based nature of staff training needs improvement.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The monitoring team determined that RSSLC had achieved SA compliance for this provision. The DADS policy on abuse, neglect, and incident management was completed on November 6, 2009. The monitoring team reviewed the policy and it was found to correspond in most respects to what is required under the Settlement Agreement. DADS reissued its abuse and neglect policies on 6/18/10. Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation and Policy 02.2 Incident Management superseded Policy 02.1 which covered both topics. Policy 2.2 includes as an exhibit the Memorandum Of Understanding between DADS, OIG, and DFPS. These policies include changes resulting from recommendations from the monitoring team's baseline reviews, clearly reflect an absolute prohibition of abuse and neglect, and require timely reporting. The DADS abuse, neglect, and exploitation rules and incident management policy state that abuse, neglect, and exploitation are prohibited. SSLCs are required to comply with these State policies and rules. RSSLC Policy C.1 Reporting Abuse, Neglect, Exploitation includes the following statement in bold print on page 1: "THE FACILITY IS COMMITTED TO ZERO TOLERANCE FOR ABUSE, NEGLECT, AND EXPLOITATION OF ANY INDIVIDUAL SERVED." This policy provides a comprehensive set of definitions for abuse, neglect, and exploitation and describes the reporting obligations and process that every employee, agent, and contractor is to follow if they suspect or have knowledge that an individual is being abused, neglected, or exploited.	SC

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		Staff interviewed were knowledgeable of the abuse and neglect policy and knew the phone number to call to report. The phone number was also displayed on the back of each employees ID badge. In its review of RSSLC UIRs and Incident Management meeting minutes, the monitoring team did not discover any instances of failure to report allegations of abuse and neglect, although there were occasional instances of late reporting. It was reported that the statewide initiative to install a video camera surveillance system at each SSLC is scheduled for RSSLC in January, 2011. It is expected this system will provide an additional measure of client protection that ensures any activity that could represent abusive or neglectful behavior is reported and investigated.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:	RSSLC had the following policies in place to address this section of the SA: 1. RSSLC Policy A.17: Managing Unusual Incidents (6/30/10) 2. RSSLC Policy A.25: Securing Evidence (7/17/09) 3. RSSLC Policy B.15: Taking Disciplinary Action Following Confirmed Abuse, Neglect, or Exploitation (8/1/07) 4. RSSLC Policy B.26 Placing an Employee on Investigative Leave (6/30/10) 5. RSSLC Policy C.1: Reporting Abuse, Neglect, Exploitation (6/30/10) 6. RSSLC Policy C.2: Actions Following Report of Abuse, Neglect, Exploitation (6/30/10) 7. RSSLC Policy C.3: Action Following Investigation of Abuse, Neglect, Exploitation (6/30/10) 8. RSSLC Policy C.5: Initial Actions Regarding Sexual Abuse, Neglect and Exploitation, and Other Sexual Incidents (12/30/02) 9. RSSLC Policy C.12: Reporting Incidents to DADS Regulatory (1/23/03) 10. RSSLC Policy D.8: Completing/Routing Client Injury Report (3/16/09) 11. RSSLC Policy D.13: Conducting an Addendum Meeting for Repeated Injuries (5/1/09) 12. RSSLC Policy D.20 Conducting an Interim Meeting for a Serious Injury (7/14/03) 13. RSSLC Policy E.17 Completing Incident Information Reports (2/28/08) 14. RSSLC Policy J.9: Conducting Interim for Repeat Incidents of Aggression (11/7/03)	N
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and	RSSLC Policy A.17 Managing Unusual Incidents establishes the reporting process. Policy requires unusual incidents to be reported to the unit director or designee. Policy also requires allegations of abuse, neglect, or exploitation to be called in to the Department of Family Protective Services (DFPS) immediately but in no case more than one hour after	N

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	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.	suspicion or after learning of the incident. The designee in off hours is the Campus Coordinator. The Unit Director or designee is to report the incident to the Facility Director's Secretary who is to notify the Facility Director as well as several other administrators. Policy requires this to occur within one hour of the initial report. Unusual incidents were defined in the policy and include serious injury and death. The facility uses a standardized form for reporting, the Unusual Incident Report (UIR). In its review of RSSLC UIRs and Incident Management meeting minutes, the monitoring team did not discover any serious incidents that were not reported. There were instances where reporting did not meet required timelines. For example, DFPS case 37764980 reports that a staff person did not report an accidental burn (curling iron) when it occurred which led to the individual not receiving medical attention for several days and the incident not being reported to DFPS for several days. This incident resulted in a finding of confirmed neglect by DFPS. In another incident, UIR 10-134 documents a serious injury that was assessed by the nurse at 10:10 p.m. It was reported to DFPS as an allegation of neglect by the campus administrator at 11:17pm. The DFPS investigation of this incident resulted in a finding of confirmed neglect. UIR 10-135 documented an injury that was assessed by the nurse at 8:30 a.m. It was reported to DFPS as an allegation of physical abuse at 11:23 a.m. The DFPS investigation of this incident resulted in an unconfirmed finding of physical abuse. UIR11-021 reported a serious injury that occurred at 2:15 p.m. It was not reported to DFPS until 5:23 p.m. The DFPS investigation of this incident resulted in a finding of confirmed neglect. The absence of timely reporting places individuals at unnecessary risk. The facility needs to improve the timeliness of reporting serious incidents and immediate implementation of client protection measures. It was reported that the statewide initiative to install a video camera surveillance system at each SSLC is scheduled for RSSLC in January, 2011. It is expected this system will provide an additional measure of client protection that ensures any activity that could represent abusive or neglectful behavior is reported and investigated.	
	(b) Mechanisms to ensure that, when serious incidents such as	RSSLC Policy C.2 Actions Following Report of Abuse, Neglect, Exploitation establishes requirements and procedures to protect individuals who are the alleged victims. Step 2	N

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	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.	in the policy delineates a number of possible actions that can be taken to ensure the safety of the alleged victim(s). These include assessing and treating any injuries, placing the alleged perpetrator (AP) on emergency leave or reassigning the AP to a non-direct care area, reassignment of the alleged victim to another group, temporary transfer of the alleged victim to another home/location, increased monitoring of the home or area by administrative staff, and, if the AP is not an employee, imposing a restriction on the AP's access to the alleged victim pending investigation. In its review of DFPS case reports, UIRs, and Incident Management Team meeting minutes, and through interview, it is apparent the RSSLC took immediate steps to remove an alleged perpetrator of abuse or neglect from client contact, including placing staff on investigatory leave when circumstances were appropriate for this action. The monitoring team did not discover, nor did investigation staff report, any instance where someone was not removed from client contact as a result of an employee identified as an alleged perpetrator having been assessed to pose no risk to individuals or to the integrity of the investigation. Occasional lack of timely assessment and reporting of an incident representing an allegation of abuse or neglect has the effect of placing individuals at risk due to this delay. For example, DFPS case 37764980 reported that a staff person did not report an accidental burn (curling iron) when it occurred which led to the individual not receiving medical attention for several days and the incident not being reported to DFPS for several days. This incident resulted in a finding of confirmed neglect by DFPS. In this case individuals were exposed to the alleged perpetrator, who was later confirmed to have been neglectful, for several days. In another incident, UIR 10-134 documented a serious injury that was assessed by the nurse at 10:10 p.m. It was reported to DFPS as an allegation of neglect by the campus administrator at 11:17p.m. The DFPS investigation of this incident resulted in a finding of confirmed neglect. UIR 10-135 documents an injury that was assessed by the nurse at 8:30 a.m. It was reported to DFPS as an allegation of physical abuse at 11:23 a.m. The DFPS investigation of this incident resulted in an unconfirmed finding of physical abuse. UIR11-021 reported a serious injury that occurred at 2:15 p.m. It was not reported to DFPS until 5:23 p.m. The DFPS investigation of this incident resulted in a finding of confirmed neglect. One of the purposes of immediately reporting incidents that may represent an allegation of abuse or neglect is to immediately identify staff that may be involved and may need to be removed from client contact pending investigation in order to protect individuals from harm. In the cases noted above this process took longer than policy requires,	

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		unnecessarily exposing individuals potentially to harm. The facility needs to improve the timeliness of reporting serious incidents and immediate implementation of client protection measures, including removal of alleged perpetrators from client contact.	
	(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.	RSSLC Policy C.1 Reporting Abuse, Neglect, and Exploitation establishes training requirements in Step 4. Policy requires that DCPs receive training on "signs of possible abuse, neglect, and exploitation" and that physicians are to receive "additional training on how to identify signs and symptoms of abuse, neglect, and exploitation." RSSLC reported in its POI that the abuse/neglect training class is offered 7 times a month. The CNE reported and review of training records confirmed that all nursing staff were trained in orientation and annually on reporting and preventing Abuse and Neglect. RSSLC employees were, for the most part, current in abuse/neglect training. Data reports indicated 99% of employees were current with course ABU0100 Abuse and Neglect. The curriculum for this course includes recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. In addition, a review of a sample of staff training records indicated all employees in the sample were current with ABU0100. The monitoring team is concerned about the effectiveness of this training and the degree to which it is competency based. The examples of documentation and other mistakes noted in Section D suggest improvement is needed.	N
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or	RSSLC Policy C.1 addresses each element required in this section of the SA. A review of personnel documentation found signed statements acknowledging reporting for each employee record sampled. The monitoring team did not discover any instances of a mandatory reporter failing to report. In interviewing the Incident Management Coordinator, he indicated he could not recall any incident of failure to report abuse, neglect, or exploitation. He did report occasional instances of late reporting. Examples discovered by the monitoring team are noted in D.2.a. From interviews with staff they were very clear there were consequences for failure to report – all responded "you'll get fired."	SC

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	neglect.		
	(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 monitoring team did not identify any RSSLC policy that was directed towards this topic. Efforts were made to educate individuals receiving services through the posting of a rights poster and through presentation and discussion at self-advocate meetings. Although the RSSLC POI reported this topic is discussed at PSP meetings, the monitoring team did not observe any discussion of this topic at the PSP meetings it attended. Other than the provision of a pamphlet there did not appear to be sufficient effort to educate every primary correspondent and LAR on identifying and reporting unusual incidents.	N
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The monitoring team found this component to be in substantial compliance. The RSSLC had a very attractive color "You Have The Right" poster to display throughout the facility. It highlighted, using pictures and words, 24 rights and included pictures and phone numbers of the Rights Officer and Assistant Rights Officer as well as 1-800 numbers to report to the DADS Consumer Rights office and the DFPS Abuse hotline. As part of routine monitoring the Rights Officer checked to see that posters were maintained. A recent 100% inspection conducted by the Rights Officer and presented to the monitoring team validated the presence of the poster at each expected location.	SC
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The monitoring team found this component to be in substantial compliance. The monitoring team found numerous examples of unusual incidents being referred to law enforcement. Through interview, the Office of Inspector General (OIG) investigator reported routine and regular referrals occurred. The monitoring team did not find, in its review of DFPS cases and UIRs, any instance of an incident not reported to law enforcement that should have been. In addition, the most recent Memorandum of Understanding (MOU) between DADS, OIG, and DFPS provides a policy framework for routine assessment by DFPS of the need to refer a case to law enforcement. The MOU is part of DADS policy on Incident Management.	SC
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of	RSSLC Policy C.1 Step 3 provides a process for anyone who believes they are being subjected to retaliatory action to report it to multiple entities. The training elements provided in Step 4 of this policy address the definition of retaliatory action, explanation that such action is prohibited, and the consequences of such action.	N

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	abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The Incident Management Coordinator reported this topic is covered in the class he teaches to all new employees and most DCP staff interviewed were aware that retaliation was prohibited and were aware there were ways to report it should it occur. None of the staff interviewed acknowledged any awareness of retaliatory acts directed at reporters of abuse or neglect. The Survey of Employee Engagement includes one question that may direct itself to this topic. "I am confident that any ethics violation I report will be properly handled." Although this does not directly refer to reporting and retaliation (but instead to the broader issue of ethics violation), it may provide an indirect measure of whether the Facility is perceived to address issues of real or perceived retaliation as those might be construed as unethical. Thirty-five percent of RSSLC employees did not agree with this statement. A somewhat similar question "There is basic trust among employees and supervisors" may also indirectly address issues of real or perceived retaliation. Fifty-one percent of RSSLC employees did not agree with this statement. The facility did not provide any information as to mechanisms to educate and protect individuals, family members, or visitors from retaliation for reporting abuse or neglect.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The monitoring team did not identify any RSSLC policy that was directed towards this topic. The monitoring team did not identify any administrative activity that directly targeted this element of the SA. Through interview, the facility lead for Section D of the SA indicated they have not, as yet, put any system in place to address this requirement of the SA. There was a type of review activity that could conceivably identify unreported injuries but it is not sufficient to represent an organized audit system. It was reported there were checks of daily home logs by the Campus Supervisor. This could identify injuries or possible injuries that should have been reported using the UIR process. It was reported that the Campus Supervisor checks these incidents on the home log to make certain they were reported correctly.	N
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,	DADS reissued its abuse and neglect policies on 6/18/10. Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation and Policy 02.2 Incident management supersede Policy 02.1 which covered both topics. These policies include modifications resulting from recommendations from the monitoring team's baseline reviews. RSSLC updated its policies on 6/30/10 to reflect changes in the State policy.. The RSSLC appears to have a well organized system for the investigatory process. It	N

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	exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:	would be well served to have this process and all its components described in one place, such as an Investigations Manual. Nevertheless, components required for compliance and described below do not yet meet all requirements and have not yet come into substantial compliance.	
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DADS Policy 2.1 establishes training requirements for investigators and anyone else that would be expected to complete a UIR. Staff must complete the Comprehensive Investigator Training (CIT0100) course within one month of employment or assignment as an investigator and prior to completing a UIR. Policy also requires that the Incident Management Coordinator and primary investigator (s) complete the Labor Relations Alternatives (LRA) Fundamentals of Investigations training (INV0100) within six months of employment. A review of personnel information and training records confirm that RSSLC investigators have completed this training. DFPS investigators training records did not document completion of required training. DFPS provided the monitoring team with a set of materials dated June 3, 2010, outlining their organization structure and training requirements. Page 9 described training requirements. These requirements are Instructor Lead Skills Development (ILSD) and advanced ILSD (ILASD). In addition, according to this document DFPS investigators are required to take Field Training which consists of 2 web-based training modules. The monitoring team was provided with Individual Training Records for 4 DFPS investigators. One of 4 records included the 3 referenced courses: 1189 MH&MR Investigations ILASD, 1188 MH&MR Investigations ILSD, and 1177 APS MH&MR Investigations Field Training One. One additional record indicated completion of course 1188. The other 2 records indicated none of the required courses had been completed. Supplemental information following the visit documented that one additional DFPS investigator received required training. A review of the RSSLC Table of Organization shows RSSLC investigators were not in the direct line of supervision of alleged perpetrators.	N
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	. The monitoring team found RSSLC to be in substantial compliance with this component. DADS Policy 2.1 establishes the principle and required expectation of cooperation with outside entities. Through interview with RSSLC staff, a Detective with the Ft. Bend County Sheriff's Department and OIG, staff cooperation in the conduct of investigations was described as generally good. Facility administration did everything expected of it by outside investigatory entities to make employees available for interview, interrogation, polygraphs, etc. The Incident Management Coordinator was clear in his understanding of	SC

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		his responsibility to fully cooperate with outside entities. RSSLC Policy C.2 Step 7 establishes a requirement that employees cooperate with DFPS investigators in all matters related to an investigation.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The monitoring team found RSSLC to be in substantial compliance with this component. Most law enforcement investigations at the RSSLC were conducted by OIG. OIG reported a high degree of coordination with RSSLC staff. There were instances where local law enforcement is involved in an investigation. Through interview, the Ft. Bend Sheriff's Department indicated RSSLC's full cooperation in investigations and not engaging in any activity interfering with an investigation. In the sample of Investigation Reports reviewed there was nothing that would indicate lack of coordination with law enforcement	SC
	(d) Provide for the safeguarding of evidence.	The monitoring team found RSSLC to be in substantial compliance with this component. DADS Policy 2.1 Section V.2 describes procedures for safeguarding evidence in the event of a serious incident. RSSLC Policy A.25 Securing Evidence contains specific RSSLC specific procedures for securing and safeguarding evidence. The Incident Management Coordinator reported he has a locked file cabinet in his office to store and safeguard evidence, and, a separate locked storage room if more space is needed. Only he and his immediate supervisor have access to these locked areas.	SC
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for	DADS Policy 2.1 Section VIII establishes timelines for investigations. This policy requires that investigations begin within 24 hours of the incident being reported and that investigations be completed within 10 days. Investigations conducted by RSSLC, as validated by UIR documentation, always commenced within 24 hours. Many started immediately upon being reported. RSSLC will soon have a system where a trained investigator is on-duty (on campus) 24 hours a day, seven days a week. This will further expedite the process to initiate investigations immediately. It was difficult for the monitoring team to determine if investigations were all completed within 10 days. UIRs provided to the monitoring team did not always have a date entry in the "review/approval" box. This would ordinarily be considered the date the investigation was completed. This was the case for UIRs 10-121, 10-098, and 11-027. Minutes of the Incident Management Team daily meeting include a column for "date of UIR, " and "due date" (which was 10 working days forward from the UIR date). It might be useful to include a column noting the completion date. This would facilitate a management oversight process to easily see if UIR investigations were being completed	N

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	corrective action.	within required timeframes. The monitoring team ordinarily considers the first face-to-face interview as representing the commencement of an investigation, as an initial interview was consistently the first investigatory action taken. Investigations conducted by DFPS did not always commence within 24 hours of being reported. For example, case 37325560 (unconfirmed physical abuse) was reported to DFPS on 8/6/10 at 11:23 a.m. The initial face-to-face interview was done on 8/9/10 at 11:00 a.m. This was approximately 3 days after being reported. Case 37303300 (confirmed neglect) was reported to DFPS on 8/4/10 at 11:17a.m. The initial face-to-face interview was done on 8/5/10 at 1:00 p.m. This exceeded the 24 hour requirement. Case 37240220 (unconfirmed physical abuse) was reported to DFPS on 8/1/10 at 1:02 p.m. The initial face-to-face interview was done on 8/3/10 at 11:15 a.m This was approximately 2 days after being reported. Case 37239780 (confirmed physical abuse) was reported to DFPS on 8/1/10 at 11:36 a.m. The initial face-to-face interview was reported on the report cover sheet to have occurred on 8/3/10 at 12:10 p.m. This was approximately 2 days after being reported. In the body of the report it appears the first face-to-face contact did not occur until 8/5/10, 4 days after the incident was reported. Case 37378880 (unconfirmed physical abuse) was reported to DFPS on 8/10/10 at 12:18 p.m. The initial face-to-face interview was done on 8/13/10 at 11:00 a.m. This was approximately 3 days after being reported. DFPS investigations were not always completed in 10 days. For example, case 36797734 (inconclusive physical abuse) was reported on 6/25/10. The DFPS report was dated 7/8/10. Case 37791960 (unconfirmed neglect) was reported on 9/4/10. The DFPS report was dated 9/27/10. In each case there was no evidence an extension was requested and/or approved. Case 37764980 (confirmed neglect) was reported on 9/3/10. The DFPS report was dated 9/13/10 although it had a "received" date stamp of 9/15/10. Presumably the received date stamp denotes the date the report was received at RSSLC. The intent of the SA is that reports were completed within 10 days and available to facility administration to use in initiating administrative follow-up. The monitoring team reviewed 23 DFPS case reports and 27 RSSLC UIRs. All consisted of written reports including a summary of the investigation, findings, and, as appropriate, recommendations for corrective action.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be	DADS Policy 2.1 Section VIII.H establishes investigation and record keeping requirements for investigation reports that include the elements required in this section of the SA. All investigation reports reviewed contained these essential elements.	N

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	sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	Investigation reports and related files were organized in a manner that was logical and easy to follow. The sample of DFPS reports reviewed contained the data elements required in this section of the SA. One DFPS report (case 37791960) did not adequately describe the investigator's reasons for the conclusion reached. This was an allegation of neglect in which a finding of unconfirmed was determined with respect to one employee and inconclusive with respect to another employee. The alleged neglect resulted from an apparent lack of direct care staff notification of a change in medical condition of an individual in a timely manner. The individual was transferred to the hospital and subsequently expired. In Section 12 of the investigation report, under probable cause, the investigator indicated "miscommunication between nursing staff and direct care staff on the nursing interventions provided to…" Given this statement, and an earlier statement in the report where the investigator says "it is highly probable that the DCS assumed that the nurses didn't follow-up because no one reported back to them, " the monitoring team would expect to see a clear rationale in the report for a finding of unconfirmed and inconclusive. None was present in the report.	
	(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 monitoring team found the RSSLC to be in substantial compliance with this component. From interview and document review it was apparent that the Incident Management Coordinator (IMC) reviewed each investigation report. The IMC is the person supervising investigations. This review was documented on a form entitled "DFPS Investigation Cover Sheet." The DFPS investigation reports were also reviewed by an Administrative Review Team consisting of the IMC, the Assistant Director for Programs, a Unit Director from a unit other than the unit where the incident took place, and the Assistant Independent Ombudsman assigned to the RSSLC. The findings from each investigation	SC

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	the investigation and/or report shall be addressed promptly.	report were also presented to the Incident Management Team for additional review, discussion, and follow-up considerations. The purpose of these reviews was reported to be to ensure reports are accurate, complete, and coherent and that any deficiencies are addressed promptly.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The monitoring team found the RSSLC to be in substantial compliance with this component of the SA. Reports were reviewed and approved by the Incident Manager and documented on a one page report that served as a cover sheet to the investigation file.	SC
	(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.	The facility was able to provide documentation showing disciplinary action that was taken with employees following investigation findings. An organized tracking system or status reporting format was not evident to the monitoring team. Within individual investigation files there was usually a tracking sheet indicating follow-up required as a result of that specific investigation. This is not a useful management tool to track all follow-up (staff related and programmatic related) that result from the administrative review investigations. It was not organized in a manner that status reports could be generated to specific administrators responsible to ensure certain actions are carried out.	N
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	The monitoring team found the RSSLC to be in substantial compliance with this component of the SA. The RSSLC maintained a log and report system that is staff specific and includes the following data items: name of individual involved, date of incident, time of incident, allegation code, allegation descriptor, DFPS case number, disposition, and, disciplinary action taken. This system permits access to every investigation involving a particular staff member or individual.	SC
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	Although the RSSLC had a tracking and trending system that included the data elements required by the SA, several data discrepancies were identified during the course of the review that raised doubt as to the reliability of these data. For example, the document request preceding the monitoring review asked for a log of all unusual incidents. This would include primarily serious injuries and incidents reportable to DFPS. At the beginning of the onsite review the monitoring team asked for this log to be updated so it would be current up to the date of the review. The updated log contained 5 serious injuries that were not on the original log even though, based on the dates of the injuries, they should have appeared on both logs. These were injuries to Individuals #16	N

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	incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	(5/4/10), #471 (7/24/10), #535 (7/23/10), #184 (6/14/10), and #483 (9/23/10). There were also instances of inconsistent information when comparing each log for the same incident. For example, an incident involving individual # 751 that occurred on 5/5/10 was noted to have occurred at 10:05 p.m. on one log and 9:00 p.m. on the other log. Similarly, an incident involving Individual #96 that occurred on 5/25/10 was noted to occur at 8:10 p.m. on one log and 8:38 p.m. on the other log. There may be very logical explanations for these discrepancies but the process that permits these inconsistencies needs to be addressed by the RSSLC.	
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.	Section 3200.3 of the DADS regulations on Volunteer Programs requires criminal background checks on volunteers. The DADS Operational Handbook, Revision 09-21 effective 10/29/09 (Section 19000 Part E) requires criminal background checks on employees. The DADS criminal history rule also contains prerequisites for allowing staff or volunteers to work directly with individuals. The monitoring team reviewed a report entitled "RSSLC Criminal Background Checks report 10/21/10 (employees and volunteers)." This report consolidated data from the Employee Misconduct Registry, the Nurse Aid Registry, the DADS Client Abuse, Neglect Registry System, and background fingerprint checks. The monitoring team accepts this report as suitable documentation for measuring compliance with this provision. In order to validate that all RSSLC employees were listed in this report the monitoring team was provided a list of all current employees. A sample of 25 was compared to names on the report. All employees sampled that were on the current employee roster were also represented on the background check report. Similar documentation was in place for volunteers who work regularly with individuals living at the RSSLC. It was reported that DADS intends to rerun fingerprint checks annually to identify any employees who have become part of the national criminal data base and did not self-report to the facility as required by policy. There is also a process in place whereby the facility is notified by DADS of any employees who has become part of the Texas databases (Misconduct Registry, Nurse Aid Registry, Client Abuse, and Neglect Registry). This enables the facility to determine if the employee self-reported the arrest as required by policy and if not the facility can take appropriate administrative/disciplinary action. Documentation reflecting this process was provided to the monitoring team and was satisfactory.	SC

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Recommendations:

1. RSSLC should assess the adequacy of staff training to ensure the intended competencies are retained by staff.
2. RSSLC should continue to work with DFPS to ensure SA timelines are met, and ensure DFPS investigators have completed prerequisite training described in DFPS policy.
3. Establish more effective mechanisms to educate individuals, family members, and LARs in recognizing the signs and symptoms of abuse and how to report.
4. Establish an audit process to ensure significant injuries are reported.
5. Establish a more defined mechanism to protect staff, individuals, family members, and LARs from retaliation for reporting abuse and neglect.
6. Establish a formal process for auditing/monitoring a sample of UIRs and DFPS reports to ensure each meets all the requirements of the SA.
7. Develop a comprehensive organized system for tracking action plans developed in response to investigation findings.
8. Assess data systems, resolve discrepancies and/or inconsistencies to ensure data reports are accurate and credible.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DADS Policy 003-Quality Enhancement 2. RSSLC Policy A.27 Quality Assurance/Quality Improvement Council 9/28/10 3. RSSLC Policy A.28 Quality Assurance Plan 10/4/10 (draft) 4. RSSLC Plan of Improvement (POI) 5/17/10 5. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10 6. ICFMR Mock Survey Plan of Correction Worksheet (undated) 7. Restraint Trend Report 9/30/10 8. Injury Trend Report 9/30/10 9. Allegations Trend Report 9/30/10 10. Unusual Incidents Trend Report 9/30/10 11. QA Monitoring tools for each provision of the SA 12. Performance Improvement Council minutes from meetings on 5/21/10, 6/22/10, 7/27/10, 8/30/10, and 9/8/10 13. Restraint Reduction Team Meeting minutes for 4/22/10 and 7/29/10 **People interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. Wilma Parker, QA Nurse 3. Brenda McClendon, Program Auditor 4. Andrea Faniel, Program Monitor 5. Adelia Pavliska, Program Monitor 6. Suzy Royer, Program Monitor 7. Judy Miller, Settlement Agreement Coordinator 8. Reuben Muhammad, Incident Management Coordinator 9. William Eckenroth, PhD, Director of Behavioral Services 10. Donald Paviska, Competency Training & Development Director 11. Carol Agu, QMRP Services Director 12. Six Direct Care Professionals **Meetings attended/Observations:** 1. Incident Management Team 10/25/10 2. HRC meeting 10/28/10 3. 10/27/10 Unit Morning Meeting at Rio Grande
	Facility Self-Assessment: The facility's self assessment reported the RSSLC was not in substantial compliance with any provision or component of this section of the settlement agreement (SA). The monitoring team's review substantiates this self assessment but determined that the RSSLC had demonstrated progress in addressing issues identified in the baseline report. For example, as of 9/28/10 the RSSLC had a quality assurance policy and

	as of 10/4/10 a draft quality assurance plan. Both documents provided general direction and, while lacking specificity at this point, represented a good beginning point for additional development.
	Summary of Monitor's Assessment: As of 9/28/10 RSSLC had a quality assurance policy and as of 10/4/10 a draft quality assurance plan. Both documents provided general direction and, while lacking specificity at this point, represented a good beginning point for additional development. RSSLC will need to ensure, as it continues to develop quality assurance plans, that the plans address all aspects of facility operations that impact services to individuals, including a written medical review system component, a written nursing quality assurance component, and a written medical quality improvement component. Current quality assurance is observably more organized than what was observed during the baseline review. There is still substantial work ahead in developing meaningful reports and analyses. For example, the facility gathered data on injuries and incidents and had a system for trending these data but there was not yet any indication this was used to address facility systems issues that might have a broad impact on reducing injuries and incidents. The facility used monitoring tools for each provision of the SA and had staff assigned to each provision. Monitoring was occurring and beginning to produce enough data to start generating reports. The QA staff was enthusiastic about their work and eager to see it impact facility operations. There is some question as to whether staff using the monitoring tools were sufficiently trained in knowing what to look for and how to assess each data item being monitored. For example, some QA reports showed a high degree of compliance that was not evident to the monitoring team during observation in the course of the review (e.g., certain elements in the meal monitoring tool). RSSLC will need to ensure that staff tasked with monitoring, especially monitoring with clinical components, have a sufficient depth of knowledge to accurately report monitoring observations and results. RSSLC has taken important initial steps that can progress into a good QA system. There is much work ahead to refine processes, integrate information, and determine how best to use all the information flowing from these current systems as well as those systems needing to be refined or developed.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	RSSLC collected the data required by this section of the SA and generated a monthly tracking and trend report. Four separate reports were generated: (1) Unusual Incidents, (2) Abuse/Neglect/Exploitation, (3) Restraints, and (4) Injuries. Each report concluded with a narrative overview and any recommendations. While the RSSLC had a tracking and trending system that included the data elements required by the SA, several data discrepancies were identified during the course of the review that raised doubt as to the reliability of these data. For example, the document request preceding the monitoring review asked for a log of	N

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		all unusual incidents. These data presumably feed into the system, or would be coming from the same data source, that generates the trend analysis report. At the beginning of the onsite review the monitoring team asked for this log to be updated so it would be current up to the date of the review. The updated log contained 5 serious injuries that were not on the original log even though, based on the dates of the injuries, they should have appeared on both logs. These were injuries to Individuals #16 (5/4/10), #471 (7/24/10), #535 (7/23/10), #184 (6/14/10), and #483 (9/23/10). There were also instances of inconsistent information when comparing each log for the same incident. For example, an incident involving individual # 751 that occurred on 5/5/10 was noted to have occurred at 10:05 p.m. on one log and 9:00 p.m. on the other log. Similarly, an incident involving Individual #96 that occurred on 5/25/10 was noted to occur at 8:10 p.m. on one log and 8:38 p.m. on the other log. A similar data discrepancy was identified when reviewing restraint data. Two documents received from the pre-review document request were updated at the time of the review and contained information on injuries to individuals during restraint. One document was a Restraints Implemented log that had a column for "injured" requiring a yes/no entry. On this document the source of the data is noted as Avatar (Restraint Checklists).The other document was a Restraints Resulting in an Injury log. On this document the source of the data is noted as Avatar (Client Injury Reports). The Restraints Resulting in an Injury Report reported 11 restraints that resulted in injury from 4/1/10 to 10/25/10. On the Restraints Implemented log no injury was indicated for 6 of the 11 restraint episodes. These were for restraints to Individuals #584, #513 (2x), #193, #740, and #630. Also on the Restraints Resulting in an Injury log were 3 restraint episodes that did not appear on Restraints Implemented log. These were for Individuals #143 ((6/7/10), # 320 (8/7/10), and #429 (4/6/10 8:45 a.m.) There may be very logical explanations for these discrepancies but the process that permits these inconsistencies needs to be addressed and reconciled by the RSSLC.	
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	Recommendations from the most recent report (9/30/10) did not reflect a level of analysis necessary to address systemic issues. The recommendation from the Unusual Incidents Trend Analysis Report is "continue increased rounds by professional staff to minimize the risk of emerging behaviors." This is exactly the same recommendation noted in the baseline report from the 3/30/10 trend report. This is an overly simplistic response to what is likely a much larger and more systemic problem related to variables such as staff interaction with individuals, staff sophistication in implementing behavior programs correctly, environmental conditions that create maladaptive behavior, and undiagnosed or untreated medical conditions.	N

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	action step; the person(s) responsible; and the time frame in which each action step must occur.	For example, the PNM team did not utilize PNMP monitoring information in their reviews. Meal observation information was used occasionally. The PNMT did not specifically review aggregated findings across homes for trend analysis to drive system change and training. There was no mechanism to track data for system analysis in order to focus training and coaching. There was no system in place to conduct trend analysis to consistently review if interventions had a positive outcome on an individual's health status. They also did not review incidence of health concerns such as aspiration pneumonia, use of bowel management aides, weight loss/gain, falls, fractures, and so forth over time to address system outcomes as a result of interventions and supports. Additionally, data discrepancies discussed in E1 cast doubt on the correctness of the data being analyzed, however rudimentary the analysis is. Through interview, RSSLC reported efforts at implementing an organized system of corrective action plans is just beginning.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Through interview, the RSSLC reported it is in the very early stages of developing an organized system directed at compliance with this provision of the SA.	N
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.	Through interview, the RSSLC reported it is in the very early stages of developing an organized system directed at compliance with this provision of the SA.	N
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Through interview, the RSSLC reported it is in the very early stages of developing an organized system directed at compliance with this provision of the SA.	N

Recommendations:

1. RSSLC needs to continue to refine its formal Quality Assurance plan and begin the process of generating useful management reports. It will be important that as the QA plan matures it capture all elements of existing QA activity throughout the organization.
2. As the QA plan matures, Facility leadership should determine if additional QA components are needed, if there are redundant elements in the plan, and if any work tasks associated with the plan are unnecessary or can be consolidated with other work tasks. This will ensure that the plan is comprehensive and manageable. It will also ensure that the plan, when fully implemented, can lead to sustained compliance with the SA and continued improvement in quality of services, safety, and other aspects of facility operation.
3. RSSLC needs to identify a more formalized process than what was evident to the monitoring team for the review of QA data and planned corrective actions, including the QA related activity associated with the Plan of Improvement process and the work of the newly constituted Quality Improvement Council and any other groups or committees that exist to assess performance and recommend improvement plans to facility leadership.

4. The issue of data discrepancies described in E.1 needs to be addressed and the facility must ensure data reports are accurate.

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:** 1. DADS Policy 004 – Personal Support Plan Process (7/30/10) 2. RSSLC Plan of Improvement (POI) 5/17/10 3. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10 3. RSSLC Policy F.1 Scheduling Annual Personal Support Plan (PSP) Meetings (6/28/10) 4. RSSLC Policy F.3 Participating in Annual Personal Support Plan Meeting (6/1/07) 5. RSSLC Policy F.4 Participating in Initial Personal Support Plan Meeting(1/28/09) 6. RSSLC Policy F.5 Completing Personal Support Plan Meeting Documentation (8/10/09) 7. RSSLC Policy F.6 Participating In/Documenting Addendum Meetings (6/1/07) 8. RSSLC Policy F.8 Participating in PSP Quarterly Reviews (6/1/08) 9. RSSLC Policy F.12 Organizing and Maintaining Active Treatment Notebooks (9/7/10) 10. RSSLC Policy F.13 Implementing and Documenting Active Treatment Programs (8/3/10) 11. RSSLC Policy F.17 Participating in PSP Monthly Reviews (7/15/09) 12. RSSLC Policy F.18 Participating in Personal Focus Worksheet Meetings 13. RSSLC Policy I.8 Health Status Team Guidelines (10/12/09) 14. Personal Support Plan Meeting Monitoring Checklist (11/6/07) 15. Section F Monitoring Tool (7/22/10, 9/13/10, and 9/23/10) 16. Personal Focus Assessments (PFA) Signature Sheets for seven individuals: Individuals #349, #526, #544, #723, #729, #736, #773 17. PSP signature sheets for Individuals #58, #267, #315, #347, #429,#448, #487, #583, and #740 18. PSPs for Individuals #14, #120, #174, #274, #286, #342, #346, #455, #630, #665, #747, and #772 19. PSP implementation in-service documentation for Individuals #347, #487, #583, and #740 20. Personal Focus Assessment (PFA) for Individuals #526 and #544 **Persons Interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. Judy Miller, Settlement Agreement Coordinator 3. Donald Paviska, Competency Training & Development Coordinator 4. Carol Agu, QMRP Coordinator 5. Six Direct Care Professionals **Meetings Attended/Observations:** 1. PSPs for Individuals #358, #500, #747, and #621 2. PFA for Individual #544 3. Human Rights Committee (HRC) meeting 10/28/10
	Facility Self-Assessment: The facility's self assessment reported the RSSLC was not in substantial compliance with any provision or component of this section of the settlement agreement (SA). The monitoring team's review substantiates

	this self assessment but determined that the RSSLC had achieved substantial compliance with one component of one provision of the SA, that being the accessibility of PSPs to direct care staff. The Facility reported that DADS issued new policy direction on PSP development on 7/30/10. The training curriculum accompanying this new policy is entitled "Supporting Visions" and is intended to reinforce that planning is to support the individuals' vision for the future for him/herself. RSSLC received training on the new policy in August, 2010. RSSLC began training its staff in September, 2010, and intends to have all staff trained by January, 2011. The new PSP format, and process, had just begun to be implemented at RSSLC at the time of this monitoring review. PSP meetings observed by the monitoring team attempted to follow the new process. The QMRPs attempted to keep discussion focused on the individual and attempts were made to draw the individual into the conversation. Staff did their best to embrace the new process but the meetings did not flow smoothly. Staff is struggling to adapt to this different way of conducting a PSP meeting. This is not surprising as a change this significant can be expected to take time to assimilate into the culture of the organization.
	Summary of Monitor's Assessment: DADS issued new policy direction on PSP development on 7/30/10. RSSLC received training on the new policy in August, 2010. RSSLC began training its staff in September, 2010, and reported over 400 staff had already received training. The new PSP format, and process, had just begun to be implemented at RSSLC at the time of this monitoring review. At the time of the monitoring visit, not all staff had received initial training on the new process. The Facility reported it intended to have all staff trained by January, 2011. The DADS policy is being implemented without the benefit of updates to RSSLC policies. As noted in the "documents reviewed" section of the Steps Taken to Assess Compliance, RSSLC had many policies directed at the PSP process. RSSLC reported it is in the process of revising facility policies to address the new PSP process. The monitoring team reviewed PSPs developed using the new process and attended four PSP meetings during the week of the review. Staff involved in the new process were, for the most part, enthusiastic and embraced the new process as it focuses on the individuals' vision for the future and his/her strengths and aspirations. Meetings were observably more interesting than those attended during the baseline review. As one might expect when a change this significant is initiated, initial implementation will have (and did have) mixed results. The Facility had recently begun to develop and implement quality assurance processes that identify and remediate problems to ensure that the PSPs are developed and implemented consistent with the provisions of this section. The monitoring team commends the Facility staff for this initiative overall although it could be improved by carefully documenting follow-up quality improvement activities and then tracking them to ensure the improvements have taken hold.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	The RSSLC POI reported noncompliance with this provision of the SA and the monitoring team concurs.	N
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.	Each PSP planning session was facilitated by one person, the Qualified Mental Retardation Professional (QMRP). This is the position in the Facility organization who is responsible for ensuring the PSP is developed, monitored, and revised as needed. For this provision to be in compliance, not only does this need to be facilitated by one individual, but team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports. The Facility was in the very early stages of implementing a new PSP process. The new PSP process called for a Personal Focus Assessment to be completed at the time of the third quarterly review to assist the PST to prepare for the annual meeting. The PSTs had begun using the new PSP format even though the PFA, on which the new PSP is intended to be based, had just begun to be implemented on 10/01/10. It was therefore not expected that PSPs would entirely reflect how the entire process should work until January 2011. Since the PFA was the first step in the new PSP process and just underway at the Facility, and is a step that was supposed to be undertaken with those team members who know the individual best, the monitoring team reviewed the signature sheets from seven of the PFA meetings held during the week of the monitoring visit. For four of seven PFAs, the signature sheets indicated that a Direct Contact Professional did not participate. For six of seven PFAs, the signature sheets indicated that there was no LAR/family participation. For three of seven PFAs, the signature sheets did not document participation by the individual. These team members, as demonstrated by their lack of attendance, did not in these instances participate in developing treatments, services, and supports.	N
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	Participation in PSP meetings included numerous clinicians. Participation by nurses, psychologists, DCPs, Legally Authorized Representatives (LARs) and family, and the individual was documented. As the new PSP process continues to be implemented, the monitoring team will review whether PST participation is dictated by the individual's preferences and needs.	N

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	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.	An essential component of the PSP process is the PFA meeting. Since the PFA was the first step in the new PSP process and just underway at the Facility, and is a step that was supposed to be undertaken with those that know the individual best, the monitoring team reviewed the signature sheets from seven of the PFA meetings held during the week of the monitoring visit. For four of seven PFAs, the signature sheets indicated that a Direct Contact Professional did not participate. For six of seven PFAs, the signature sheets indicated that there was no LAR/family participation. For three of seven PFAs, the signature sheets did not document participation by the individual. Therefore, staff who regularly and directly provide services and supports to the individual were not involved in this important step of the PSP planning process. For one of two PFA meetings observed during the monitoring visit, the individual was not supported to participate in a meaningful or appropriate way: For Individual #544, the PFA meeting was held during a time the individual was usually at work. During the meeting, the individual expressed on a number of occasions that he needed to be at work. The PST expressed their awareness of the individual's anxiety when he was not able to go to work as expected, but had not factored that into the decision as to the time the PFA meeting was scheduled. As a result, the individual was not able to focus on and actively participate in the proceedings of the PFA meeting. This was brought to the attention of the PST members by the monitoring team, who were very receptive and later reported that they had incorporated that advice by scheduling the individual's PSP for a late afternoon after the individual's normal work hours. Also, Individual #544 could communicate verbally, but his speech was often difficult to understand, which staff acknowledged. The PST had trouble understanding his responses to questions about his preferences. The monitoring team suggested that PST consider some additional support be provided in this area, such as using pictures to help the individual indicate preferences. The PST was again receptive and noted in the PFA that the individual needed to be re-evaluated for a communication dictionary. It was later reported that this PST used pictures in the PFA meeting they held for another individual later in the day.	
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.	Annual assessments were completed timely for most disciplines. Assessments in response to changes in function or status were not always done, and such changes were not always evaluated thoroughly even through the annual assessment process. Assessments were not always based on current evaluations and did not always include summaries or rationales to explain how evaluation results led to conclusions and recommendations. According to an interview with the Assistant Director of Programs, the PST was to	N

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		determine at the PFA meeting which assessments were needed for the PSP. For the PFA observed for Individual #544, the PST did not ensure that all appropriate assessments were recommended. The individual could communicate verbally, but his speech was often difficult to understand, and the PST had trouble understanding his responses to questions about his preferences. The monitoring team suggested that PST consider some additional support be provided in this area, such as using pictures to help the individual indicate preferences. The PST was receptive and noted in the body of the PFA that the individual needed to be re-evaluated for a communication dictionary, but failed to include any assessment for communication skills in Section III of the PFA, which specifies the assessments to be completed for the PSP. The monitoring team also requested all of the assessments for two individuals that were completed in advance of the annual PSP held during the week of the monitoring visit. For one of the two individuals, not all prescribed assessments were found in the requested documentation. For Individual #358, the PFA held prior to the PSP recommended a Psychological assessment be completed. This assessment was not included in the packet of requested assessment material. None of the 17 Psychological Assessments reviewed had documentation to support that the information contained in the Assessment was current, accurate and relevant to the understanding of the individual's strengths and needs. Assessments were based on outdated evaluations, and there were no narrative summaries of how the results from adaptive or intellectual assessments would facilitate the understanding of the individual's strengths and needs. Psychiatric evaluations were detailed and their overall quality was good, although they did need to better identify the particular behavioral characteristics of the psychiatric disorders that were diagnosed. However, at the time of the compliance tour, only about 60% of individuals who needed psychiatric assessments had received them. Issues were also identified in Physical Nutritional Management (PNM) planning. Examples of where the PNM Team did not meet regularly to address change in status, assessment, clinical data and monitoring results included: • Individual #84 was diagnosed with aspiration pneumonia on 5/21/10. There was no evidence of a review by the PST to discuss the incident or assessment to determine cause of the event or to determine if a return to oral intake was a possibility. • Individual #439 was diagnosed with aspiration pneumonia on 7/5/10. There was no HST or PST response to the incident. • Individual #223 was diagnosed with aspiration pneumonia on 1/14/10. No	

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		assessment was conducted post incident to fully determine swallow function nor was there evidence of team review • Individual #436 was diagnosed with aspiration pneumonia on 2/19/10 and 7/4/10. There was no evidence of assessment or investigation as to the root cause of the incident. There was also no evidence that the PNM team met to discuss the issue. Individual #217 had a choking event on 7/13/10. There was evidence that OT observed a medication pass and mealtime but there was no evidence of follow up beyond the observation. There is also no evidence of a comprehensive oral motor assessment to determine if there was a decline in swallow function.	
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.	The new PSP process called for all assessments to be placed in a shared electronic folder and to be reviewed by all team members prior to the PSP. Although this new process encouraged PST members to come to the meeting well-versed in the assessment results so that discussion could focus on how to address risks and on selection of supports and services, discussions of those continued to be limited. It is essential that the PST have an interdisciplinary discussion and understanding of the nature of all important risk factors in order to address the needed protections, supports and services. The monitoring team requested and reviewed all of the assessments for two individuals that were completed in advance of the annual PSP held during the week of the monitoring visit. For 4 of 4 PSPs observed during the monitoring visit, the PST failed to ensure assessments and their results, particularly as they related to potential risk factors, were sufficiently addressed in the development of the annual plan. Examples include: • For Individual #358, there was a nursing assessment completed for the PSP, which documented a significant history of congestive heart failure. The RN Case Manager at the PSP meeting noted that she had "just taken over her case last week." The only health care issue discussed was the individual's need to keep legs elevated and or use compression stockings; no other health risks or potential indicators related to the edema for staff to be aware of were discussed. Individual #358 had an OT/PT assessment for the PSP that documented a history of choking. This was not specifically discussed at the PSP meeting, other than to acknowledge that the individual should use a small adapted spoon. • For Individual #747, the RN Case Manager reported at the PSP meeting that the individual was "basically doing fine" as to health status. It was reported that the individual had no falls, gait was good and there were no apparent side effects to medication. It was noted that the individual was overweight and there was discussion of encouraging healthier diet choices and increased exercise, but there was no discussion of the individual's significant cardiac health condition, the potential risks it entailed or how it should be monitored.	N

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		The monitoring team appreciated the goals of the new PSP process to 1) focus more on individual preferences, and 2) spend less time on the one-by-one review of assessments during the PST meeting, but the process needed to find a better balance between these admirable goals and ensure that important assessment information is identified and addressed in an interdisciplinary manner. This does not suggest returning to a format in which reports were read at the meeting; instead, having the reports available to all PST members in advance should permit them to identify issues needing discussion, including issues raised in an assessment that may affect decisions on one or more aspects of the treatments, supports, and services to be planned.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	While DADS policy and the SA explicitly state that the decision of the LAR regarding community placement is to be honored, the ADA and Olmstead decision call for a person to be served in the most integrated setting appropriate to their needs as determined by qualified professionals unless the individual or LAR objects. For 4 of 4 PSPs observed during the monitoring visit, and for twelve of twelve PSPs reviewed, the PST failed to adequately consider and provide an assessment, by qualified professionals, of the most integrated setting appropriate for the person. The PSTs largely deferred their assessment, including the protections, services and supports the individuals would need in the most integrated setting, in light of the guardians' or family's opposition to community placement. Examples include: • For Individual #358, the PST did attempt to discuss community living options and possible barriers with the guardian, who was in attendance at the PSP meeting and expressed her opposition. In the face of this opposition, however, the team did not provide any assessment of the most integrated setting appropriate to the individual's needs by professional standards. • At his PSP, Individual #747 stated that he wanted to live in a group home. His guardian, who was also at the meeting, was opposed. The PST did discuss possible awareness strategies, which was to be commended, but did not provide its assessment of the most integrated setting, by professional standards, appropriate to the individual's needs, taking into account his own stated preferences or strengths, abilities and needs. One member of the team did state that the individual was "ready to leave," but this was not reflected in the completed PSP. The completed document stated that the PST along with the individual's family and guardian agreed that the most integrated setting at the current time was for him to continue to live at the Facility. The team did discuss the needs of the individual and the family for additional education in the area of community living, but this rationale for recommending continued stay at the Facility fell far short of providing a professional assessment of the most integrated setting suitable for the individual.	N

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		• For Individual #665, the PSP noted the individual preferred to live in the community. The PST documented that many of the individual's needs could specifically be met in the community; in other instance, the PST indicated the types of supports, including medical and behavioral supports that would be needed in the community. The individual's sister was noted to oppose community placement. The PST proceeded to recommend that, "based on the above information," the most integrated setting for the individual was the current placement "due to [the individual's] medical and behavior needs," even though the PSP did not document anywhere how these medical and behavioral needs would be a barrier to community living.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:	The monitoring team found this provision not to be in compliance.	N
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:	The monitoring team found this provision not to be in compliance.	N
	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;	The Facility was in the very early stages of implementing a new PSP process, which called for a Personal Focus Assessment to be completed at the time of the third quarterly review to assist the PST to prepare for the annual meeting. The PSTs had begun using the new PSP format even though the PFA, on which the new PSP is intended to be based, had just begun to be implemented on 10/01/10. It was therefore not expected that PSPs would entirely reflect how the entire process improvements in how the individual's preferences would be identified and prioritized so they could be addressed during PSP planning. In PSP meetings attended the preferences of the individual were identified and discussed but usually in a perfunctory manner. For Individuals #500 and #621 this consisted primarily of "he likes….." without significant input from the individual or direct care staff. In neither PSP meeting was any attempt made to prioritize preferences. Neither of these PSP meetings included focused discussion on the individual's strengths or on barriers preventing or delaying implementation of services construed as important to the individual.	N

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	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;	PSPs reviewed contained Action Plans but most did not contain complete or specific information. For example, the Action Plan for Individual #342 did not contain specific information as to when a specific action is to occur and stated for most actions a standard response in the comments section of "review quarterly." In reviewing PSPs the monitoring team could not, in most cases, identify language that addressed the specific and measurable goals and the strategies to accomplish them. Barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies. At his PSP, Individual #747 stated that he wanted to live in a group home. His guardian, who was also at the meeting, was opposed. The PST did discuss possible education strategies to promote awareness and understanding of community living, but did not include any formal Action Plans to address this identified need.	N
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Assessments were not discussed during PSP planning meetings to identify how information from assessments would lead to either specific services developed by other disciplines or goals that were complementary. For example, for Individual #747, during the annual PSP meeting for individual #747 on October 28, 2010,: • The PST identified the individual's prioritized preferences included wanting to work more to earn more money and a newly-identified affinity for animals, particularly horses. The PST discussed Action Plans around additional work, such as the possibility of doing shredding on the residence in addition to the workshop, and discussed outings to the zoo and being evaluated for horseback riding therapy, which is provided on Facility grounds. There was no discussion as to whether, or how, his interest in animals could be coordinated with his vocational options, even though there is a stable on the facility grounds that could provide such opportunities. • The PST members corroborated that clinical services are rarely incorporated into the PSP process. Importantly, they were unaware of many serious issues such as ischemic vessel disease and lacunar infarcts of the brain, a possible history of a myocardial infarct and the impact of hypertension in an African American Male. They were also unaware that the individual was a PPD converted and the importance of careful monitoring for tuberculosis. Also, the PST was unaware of possible changes in the DISCUS and MOSES. Both the DISCUS and MOSES indicated no movement disorder, however, during the PSP the individual clearly demonstrated significant signs of a movement disorder that included lip smacking, mouth and tongue movements, slow perseverating speech and slow gait. Ultimately, as a result, guardians were not fully made aware of clinical diagnosis, prognosis and many treatments offered by the Facility, and decisions on supports needed both currently and for movement to a	N

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		more integrated environment were not based on complete information. PSPs contained reference or a brief statement of an individual's communication skills but did not provide integration of the utilized devices or strategies into existing action plans resulting in a decreased opportunity for generalization and/or acquisition of skills.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	PSPs reviewed contained the required Action Plans but most did not contain complete or specific information. For example, the Action Plan for Individual #342 did not contain specific information as to when a specific action was to be taken. In reviewing PSPs the monitoring team could not, in most cases, identify language that identified methods for implementation and the specific staff responsible.	N
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	PSPs reviewed contained the required Action Plans but most did not contain complete or specific information. For example, the Action Plan for Individual #342 does not contain specific information as to when a specific action is to occur and in most cases a standard response in the comments section "review quarterly". In reviewing PSPs the monitoring team could not, in most cases, identify language that addresses the requirements of this component of the SA. Many habilitation training programs included the use of task analysis, which is a useful tool in developing effective programs to teach new skills. This should be continued and could be expanded to the development of behaviors to replace targeted problem behaviors when function of the target behavior has been identified.	N
	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.	PSPs reviewed contained the required Action Plans but most did not contain complete or specific information. For example, the Action Plan for Individual #342 had a standard response in the comments section to "review quarterly." Data being identified by the Facility for collection may not have been adequate to permit objective analysis of the individual's progress. • In 36 of 36 records reviewed (100%), data collection on behaviors targeted in PBSPs for reduction consisted of "DRA Data Sheets" that allowed for the recording of low frequency displays of behavior combined with narrative statements concerning the display context. This single approach to data collection might not be useful for all targeted behaviors. That is, in addition to being designed to make it possible for DCPs to collect accurately and efficiently, the data system needs to provide information that allows assessment of both behaviors that occur at low rates (e.g., intense but infrequent aggressive behavior), as well as behaviors that occur at very high rates (e.g., stereotypic behavior, undesirable verbal behavior). Depending on the target behavior and its frequency, the Facility should use a range of measures	N

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		• In 36 of 36 records reviewed (100%), there was no indication of attempts to collect interobserver agreement on treatment data to determine that definitions were adequate and ensure that the data could be valid. • Data presented for consideration at the psychiatric clinics was heavily dependent on information collected by the psychologist for targets of psychological/behavioral interventions. To the extent that medication treatment plans existed, they relied on existing behavioral targets, even when these did not reflect the relevant behavioral symptoms of the psychiatric diagnosis. • In none of the 19 PNMPs reviewed were clinical indicators associated with PNM decline present.	
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.	One of the goals of the new PSP process was to ensure that individuals' preferences form the basis for the goals, objectives, anticipated outcomes, services, supports, and treatments of the individual's own PSP and lead to the development of integrated and coordinated Action Plans. For four of four PSPs observed, two of two PFAs observed, and for 12 of 12 PSPs reviewed, the PST did not adequately coordinate goals, objectives, anticipated outcomes, services, supports, and treatments. For example, for Individual #747, the PST identified the individual's prioritized preferences included wanting to work more to earn more money and a newly-identified affinity for animals, particularly horses. The PST discussed Action Plans around additional work, such as the possibility of doing shredding on the residence in addition to the workshop, and discussed outings to the zoo and being evaluated for horseback riding therapy, which is provided on Facility grounds. There was no discussion as to whether, or how, his interest in animals could be coordinated with his vocational options, even though there is a stable on the facility grounds that could provide such opportunities. There was no consideration as to introducing him to other work related to animals, such as visiting a veterinary clinic in the community. Additionally, goals and objectives that were implemented by Habilitation Services were not integrated or represented in the PSP. Examples include treatments provided for individuals #185, #321, and #613.	N
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.	Staff reported the PSP was accessible to them in their work areas and they were organized and written in a manner that was understandable. However, as documented in Provisions F2a(2), F2a(4), K11, and R3, some action plans or other supports and service plans did not include all necessary information or were written in complex language, and were not implemented accurately.	N
F2d	Commencing within six months of	From the record review it was evident monthly and quarterly reviews took place. The	N

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	the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	lack of qualitative substance in some PSPs and of data available for clinical indicators of efficacy described elsewhere in this document made this monthly review, for many individuals, perfunctory. For example, behavior data were graphed for monthly progress review. Because of the manner in which these data were graphed, such as multiple graphs for one PBSP, no indication on the graphs of treatment or environmental changes, and the lack of labels for axes and other components of the graphs, it was not typically possible to effectively use the graphs for determination of treatment efficacy. In some areas, there was no evidence of monthly review. For example, there was no evidence in the records submitted of monthly reviews by the PST or member of the Nutritional Management Committee that focus on the individual's progress or response to interventions provided by therapy or direct support staff related to nutritional management plans.	
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	The Facility had begun to provide training on a new PSP process for staff responsible for the development of individuals' PSPs. Training in the new Supporting Visions curriculum has been ongoing at the Facility since 9/3/10. According to the Report to Monitors provided at the entrance meeting, 426 staff had been trained in the new process. The training curriculum was reviewed. There was not a competency evaluation component. As described in section F.2.g, the Facility had begun to evaluate the performance of the PSTs during PSP meetings. The Facility also reported it had engaged in some mock PSP meetings, both as a training and evaluation tool and that it intended to implement additional mock meetings. Staff did not always receive timely competency based training on individuals' plans for whom they are responsible. RSSLC policy stated, and administrative staff reported, that the expectation is that direct care staff receive specific training within 10 days of the completion of a PSP or PSP Addendum. From documentation received by the monitoring team this training consists of an in-service usually provided by the QMRP. These did not always occur timely. For example, Individual #342's PSP meeting was 9/1/10. Staff inservicing did not begin until 9/24/10 and was not completed until 9/29/10. Individual #772's PSP meeting was 9/1/10. Staff inservicing did not begin until 9/22/10 and was not completed until 10/1/10. There is also considerable question as to the competency based nature of these in-services. Direct care staff interviewed described the in-services,	N

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	updated competency- based training when the plans are revised.	for the most part, as merely an explanation of services to be provided. None of the direct care staff interviewed reported the in-service included a demonstration of program implementation technique. None of the direct care staff interviewed reported being asked to describe to the trainer what they had just learned to demonstrate understanding. RSSLC Policy F.13, Implementing and Documenting Active Treatment Programs, describes the content that is to be included in these in-services: 1) knowledge of why program activities are presented, 2) knowledge of the materials and equipment needed to teach the specific skill, 3)how to read the methodology section of the program plan, 4) how to implement the program strategies, 5) how to document the training on the data sheets, and, 6) how to provide opportunities for generalization of skill. From staff interviews of staff who would have been the recipients of these in-services it appeared unlikely each in-service included all elements, in any substantive manner, called for in this policy.	
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 monitoring team reviewed PSP dates for 115 individuals. Ten did not meet the criteria for occurring within one year of the prior PSP. For example Individual #12 had a PSP meeting on 8/29/08. The next PSP meeting was on 9/28/09, thirteen months later. Individual #551 had a PSP meeting on 10/28/08. The next PSP meeting was on 12/8/09, more than thirteen months later. Individual #146 had a PSP meeting on 11/4/08. The next PSP meeting was on 12/9/09, thirteen months later. Nearly 10% of PSP meeting dates exceeded the annual requirement called for in the SA.	N
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The Facility had recently begun to develop and implement quality assurance processes that identify and remediate problems to ensure that the PSPs are developed and implemented consistent with the provisions of this section. Quality Assurance staff were completing record reviews using a version of the monitoring team's Section F monitoring tool. In addition, Quality Assurance staff and the QMRP Coordinator were using the Section F monitoring tool and the PSP Monitoring Tool to audit PSP meetings for certain key indicators. The monitoring team reviewed a sample of the monitoring tools based upon those findings. The monitoring tools required that for each "NO" response indicating the team did not adequately address the item, the QMRP Coordinator or observer was to document what was missing and the date in which the issue was discussed with the PST member.	N

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		For six of seven of the observation monitoring tools that included "NO" responses, there was no specific documentation offered as to the follow-up action taken. The same was true for two of two record review monitoring tools that included "NO" responses. In at least one such instance, the monitoring team was aware that the QMRP Coordinator met with the PST following the PSP meeting to debrief and offer coaching; however, this was not clearly documented as a coaching or corrective activity. The monitoring team commends the Facility staff for this initiative overall. It could be improved by carefully documenting follow-up quality improvement activities and then tracking them to ensure the improvements have taken hold.	

Recommendations:

1. Continue training staff on the Supporting Visions PSP process.
2. Continue monitoring PSP meetings and provide immediate feedback to teams on process improvements needed. These quality improvement activities should be carefully documented and tracked to ensure the improvements are sustained.
3. Establish mechanisms that are intended to foster greater interdisciplinary integration in assessments and program planning.
4. Improve efforts to ensure direct care professionals, guardians, and LARs attend and participate in PFAs and PSPs.
5. Update RSSLC policies that are directed towards the PSP process.
6. Improve the timeliness of staff training on an individual's PSP and take steps to ensure the training is competency based.
7. Work with DADS to develop a competency based component to the Supporting Visions training.
8. Develop better tracking systems to ensure PSPs occur annually.

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI) 5/17/10 2. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10 3. PSP /PSP Addendums and Consent Form for Positive Behavior Supports During an Active Treatment Program with attachments for Individual #448 4. PST Signature Sheet for PSP meeting for Individual #500 5. PSP for Individual #500 11/02/09 **People Interviewed:** 1. Tran Quan, DO, Director of Medical Services 10/28/10 2. William Eckenroth, Ph.D. Director of Behavioral Services 10/26/10 3. Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report **Meetings Attended/Observations:** 1. Human Rights Committee (HRC) 10/28/10 2. PSPs for Individuals #358, #500, #747, and #621 3. Personal Focus Assessment (PFA) for Individual #544
	Facility Self-Assessment: RSSLC reported that no Action Steps for this Section had been completed. The Facility reported progress in that integration of pharmacy and psychiatry in the medical morning meeting began in August, 2010. Several Action Steps referred to current systems in place to integrate services; as integration was not always found, these current systems did not always result in actual integrated planning. Several of the Action Steps also referred to annual planning and revision but did not refer to assessment and action when there is a change in status. In regard to review of non-facility clinician recommendations, the Facility Action Plan reported that a form will be established to document when the PCP accepts or declines the recommendation and whether PST involvement is necessary. Although this would be a good beginning, it would be important to revise this plan in two ways. First, the form should indicate the reason when a recommendation is declined. Second, there should be clear criteria for what requires consideration by the PST (and whether it is the full PST or specific disciplines along with the QMRP) rather than simply giving the PCP full authority for the decision. Also, because not all non-facility recommendations are made to the PCP (for example, recommendations for PBSPs might come from a non-facility behavior analyst directly to the Facility behavior analyst), the plan might be expanded to make the same rules regardless of the Facility clinician receiving the recommendation.
	Summary of Monitor's Assessment:

	Progress has been made as processes have been established which may lead toward integrated clinical services. Integrated planning is beginning to occur but is not yet routine. **Provision G1:** The new PSP process promotes integrated planning but had just begun implementation at RSSLC. Participation documented in PSP meetings included numerous clinicians. Although progress had been made in integrating clinical services, disciplines still operated relatively independent of each other when carrying out assessments and developing interventions. Review of risks of interventions by the PST was not thorough and was not always reflected in the PSP, even when individual clinicians identified those risks. **Provision G2:** Recommendations were generally reviewed and signed or initialed. PST documentation did not generally reflect reasoning for choosing to adopt or reject recommendations.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	Progress has been made as processes have been established which may lead toward integrated clinical services. Integrated planning is beginning to occur but is not yet routine. The new PSP process promotes integrated planning but had just begun implementation at RSSLC. Participation documented in PSP meetings included numerous clinicians. Participation at the PSP meeting for Individual #500 by a nurse, psychologist/behavior analyst, DCP, PNMP coordinator, recreation coordinator, social worker, and the individual was documented. However, PST members whose participation was essential due to an individual's needs were not always present; although this individual's PSP developed in 2009 stated the individual's mother did not want the individual to move "because [the individual] is medically fragile and [the individual's] health is at risk" there was not a physician at the PSP meeting. For the PFA observed for Individual #544, the PST did not ensure that all appropriate assessments were recommended. The individual could communicate verbally, but his speech was often difficult to understand, and the PST had trouble understanding his responses to questions about his preferences. The PST failed to include any assessment for communication skills in Section III of the PFA, which specifies the assessments to be completed for the PSP. The monitoring team also requested all of the assessments for two individuals that were completed in advance of the annual PSP held during the week of the monitoring visit. For one of the two individuals, not all prescribed assessments were found in the requested documentation. For Individual #358, the PFA held prior to the PSP recommended a	N

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		Psychological assessment be completed. This assessment was not included in the packet of requested assessment material. Although progress had been made in integrating clinical services, disciplines still operated relatively independent of each other when carrying out assessments and developing interventions. • RSSLC psychologists and psychiatrists had a close working relationship. This was particularly evident in the twice monthly psychiatric clinics that were conducted by a part time psychiatric consultant and also included participation by a nurse. This clinic was the place where most of the decisions about psychotropic medication management were made. Prior to each clinic, psychologists (and other PST team members) prepared summaries of the current behavioral data, as well as a historical review of that data. Psychologists also provided a written summary spelling out their analysis of the individual's status; although this is a positive step and can be valuable for both diagnosis and selection of treatment, weaknesses in psychological assessment (including functional assessment) may have made these analyses less valuable than they could be. With the above in mind, it was clear that there was considerable involvement of the psychologists in the process of the administration and prescription of psychotropic medication. Nonetheless, there were several factors which precluded meaningful integration of psychiatric and psychological treatments through combined assessment and case formulation. The very busy schedule – at least 25 individuals needed to be reviewed during each clinic – focused on matters of immediate clinical management. Understandably, the consultant did not have the time to undertake careful case analysis and case formulation. Certainly, neither he nor the Facility psychologists had the ability to reflect on the far more complex issues of combined interdisciplinary assessment and case formulation. The consultant's notes from the clinic session reflected these realities. With recent employment of staff psychiatrists, the Facility planned to begin having the psychiatrists participate in the PST/PSP development process. • Per report from Dr. Quan, the clinical pharmacist began attending the morning physicians' meeting each Wednesday. Psychiatrists had also begun attending the Wednesday morning meeting. This provides an opportunity for integrated discussion of cases and issues. The Facility planned to begin including nursing management and the director of habilitation (for PNMP) to participate two days per week.	

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		• According to Dr. Quan, the physician and nurse supporting each individual meet together with the pharmacist to discus health care issues. The monitoring team was not made aware of any of these meetings and was not provided documentation. This will be reviewed at the next compliance visit. • Review of risks of interventions by the PST was not thorough and was not always reflected in the PSP, even when individual clinicians identified those risks. For Individual #448, for whom restraints had been used periodically, the Consent Form and attachments identified numerous risks, including GERD, history of open chest surgery, pacemaker/vagal nerve stimulator, and prone to have subluxation of cervical spine. The PSP Addendum of 7/29/10, under Risk vs. Risk of Restraint, overlooked all that and stated, "The PST is aware of the numerous restraints but find it necessary due to [Individual #448] aggression towards self, others and environment." Risk was not addressed by the PST, even in a section of the form devoted specifically to consideration of risk. • Individuals who received direct and indirect PNM and OT/PT supports received annual OT/PT assessments in addition to medical, nursing, and nutritional assessments provided annually to each individual. Assessment was not specifically driven by level of health risks. These were discipline-specific assessments with the exception of the OT/PT assessments, and little collaboration at the time of assessment was noted among professional staff for any individual, and certainly not for those at highest risk. • RSSLC recently formed a PNM team. As of this review, the team had met 4 times. The primary function of the team at this point had been to review and provide a comprehensive assessment to individuals who are at an increased risk; however there are no clear criteria for determining who is truly at risk. The PNM team was providing comprehensive assessment to one individual on a weekly basis, and then reviewing that individual at the following meeting. The PNM team consisted of a qualified Speech Therapist (SLP), Occupational Therapist (OT), Physical Therapist (PT), Registered Dietitian (RD) and Registered Nurse (RN) but did not consistently include a Physician or Behavior Analyst. Due to the medically high risk nature of the individuals who will be the focus of the meetings, a physician would be needed so that a true comprehensive discussion may be provided and medical implications addressed. Additionally, because many issues associated with physical and nutritional decline are linked to behavioral issues, a behavior analyst would be a valuable member of the team. • There was no evidence of collaboration between nursing and habilitation services with regards to development of the care plan nor was there reference to the PNMP which contained much information that would assist in mitigating the risk. • Results from the speech assessment were only mentioned in the PSP. Rationales	

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		and descriptions of communication interventions regarding use and benefit were not clearly integrated into the PSP. Strategies were sometimes listed but these strategies were not consistently integrated into Action Plans or activities of daily living. • The PST was not meaningfully made aware of clinical issues and as a result important and serious medical conditions are not incorporated into the PSP. During the annual PSP meeting for individual #747 on October 28, 2010, the entire PSP team that attended the meeting corroborated that clinical services were rarely incorporated into the PSP process. Importantly, they were unaware of many serious issues such as ischemic vessel disease and lacunar infarcts of the brain, a possible history of a myocardial infarct and the impact of hypertension.	
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.	Recommendations were generally reviewed and signed or initialed. More is required to document review than simply initials of the facility clinician; documentation must also include whether or not to adopt recommendations or whether to refer to the PST. Clinician and PST documentation did not always reflect reasoning for choosing to adopt or reject recommendations. For example, for Individual #390, documentation of review of the consultant's report by the facility physician to show that the recommendation was considered was not present.,	N

Recommendations:

1. Continue the development and implementation of the revised PSP process with coaching and monitoring to promote interdisciplinary planning and decisions.
2. Ensure that all policies regarding treatment planning reflect the need for integration across disciplines.
3. When a form is developed to document acceptance or non-acceptance of recommendations by non-Facility clinicians, the form should indicate the reason when a recommendation is declined. Furthermore, there should be clear criteria for what is to be considered by the PST

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI) 5/17/10 2. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10 3. PSP /PSP Addendums and Consent Form for Positive Behavior Supports During an Active Treatment Program with attachments for Individual #448 4. PST Signature Sheet for PSP meeting for Individual #500 5. PSP for Individual #500 11/02/09 **People Interviewed:** 1. Tran Quan, DO, Director of Medical Services 10/28/10 2. William Eckenroth, Ph.D. Director of Behavioral Services 10/26/10 3. Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report **Meetings Attended/Observations:** 1. Human Rights Committee (HRC) 10/28/10 2. PSPs for Individuals #358, #500, #747, and #621 3. PFA for Individual #544
	Facility Self-Assessment: RSSLC reported that no Action Steps for this Section had been completed. The Facility reported progress in that physician and nurse care is continuously available, a new psychiatrist had been hired, and psychology coordinates with habilitation. The Facility reported that annual medical summaries are provided and are tracked by the Medical Records Department. The Facility reported that "emergent (sic) respiratory assessment is assessed by the medical provider and documented vital signs and clinical physical exam documented in the IPN." The Facility reported Health Management Plans (HMPs) are reviewed monthly. Although these are appropriate actions, they do not, by themselves, lead to high quality clinical care or to use of clinical indicators to ensure timely response to changes in an individual's health or behavioral status. The Facility reported that "Nursing and medical collaborate with psychology, psychiatry, habilitation, and the PST to coordinate treatment for the individual." As indicated in Section G, such coordination is occurring but is in early stages and does not yet involve consistent integration into the PST process and the PSP.
	Summary of Monitor's Assessment:

	Scheduled assessments were completed timely. There was progress on establishing an interdisciplinary process that may lead to recognition of changes in health and behavioral status that need timely response. Changes in status were not always recognized and reported, discussion awaited scheduled meetings, and there were not thorough assessments when there was decline in function. Assessments were not always based on current evaluations and did not always include summaries or rationales to explain how evaluation results led to conclusions and recommendations. Diagnoses were consistent with diagnostic criteria, but it was not clear that diagnoses were complete and were updated as an individual's functional or health status changed. Use of clinical indicators for review of progress was variable, which might be one reason why changes in status did not lead to action.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Per interview with Dr. Quan, physicians rely on nurses, DCPs, and the PST to report changes in status. There are no specific protocols for clinical indicators. The Facility is considering developing health care protocols to guide provision of services and training of nurses and DCPs on indications to observe to improve detection and reporting of changes in status. Annual assessments were completed timely for most disciplines. Assessments in response to changes in function or status were not always done, and such changes were not always evaluated thoroughly even through the annual assessment process. Assessments were not always based on current evaluations and did not always include summaries or rationales to explain how evaluation results led to conclusions and recommendations. • All Annual and/or Quarterly Nursing Assessments reviewed were completed according to their Personal Support Plan schedules. All had a Braden Scale skin risk assessment completed on each Annual and/or Quarterly Nursing Assessment. There was evidence of progressive improvement since the baseline review in both quality and substance of the Nursing assessment sections, including comment/summary sections related to relevant assessment items as well as in the nursing Summary sections. The most noticeable improvements were found in the annual and quarterly assessments completed after the implementation of the modified Comprehensive Nursing Assessment Form. • Individual #390 was known to have extreme behaviors that would result in self-injury and potential injury to others. Such behaviors were exacerbated by movement and abated at rest; however, the PST did not recognize this important factor. Such extreme behaviors usually indicate an underlying health care issues	N

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		that results in pain and/or discomfort. The individual had known cervical spine disease, but there was no clinical follow-up to rule out worsening degeneration, which could easily account for loss of function and behavior exacerbation and possibly contribute to the individual's death. The individual also had a known diagnosis of GERD with enlarged rugae folds and history of gastritis and there was no indication of clinical follow-up for this condition. There was no clinical evaluation or reported differential diagnosis for the individual's abnormal balance and gait problem. • Based on a review of 19 individual records, documentation supported that the PNM Team did not meet regularly to address change in status, indicators of increased risk, clinical data and monitoring results. Individual examples of where the PNM Team did not meet regularly to address change in status, assessment, clinical data and monitoring results included: o Individual #84 was diagnosed with aspiration pneumonia on 5/21/10. There was no evidence of a review by the PST to discuss the incident or assessment to determine cause of the event or to determine if a return to oral intake was a possibility. o Individual #439 was diagnosed with aspiration pneumonia on 7/5/10. There was no HST or PST response to the incident. o Individual #223 was diagnosed with aspiration pneumonia on 1/14/10. No assessment was conducted post incident to fully determine swallow function nor was there evidence of team review o Individual #436 was diagnosed with aspiration pneumonia on 2/19/10 and 7/4/10. There was no evidence of assessment or investigation as to the root cause of the incident. There was also no evidence that the PNM team met to discuss the issue. o Individual #217 had a choking event on 7/13/10. There was evidence that OT observed a medication pass and mealtime but there was no evidence of follow up beyond the observation. There is also no evidence of a comprehensive oral motor assessment to determine if there was a decline in swallow function. o Individuals newly admitted to the Facility had a psychological assessment completed within 30 days of admission. Records did not reflect that individuals admitted to the facility routinely received an intellectual or adaptive assessment at the time of admission regardless of the duration of time since the most recent assessment. Observations indicated this pattern continued throughout the time an individual lived at the Facility. There were no indications that new intellectual or adaptive assessments were conducted once a person began to live at the Facility. o None of the 17 Psychological Assessments reviewed had documentation to support that the information contained in the Assessment was current, accurate	

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		and relevant to the understanding of the individual's strengths and needs. Assessments were based on outdated evaluations, and there were no narrative summaries of how the results from adaptive or intellectual assessments would facilitate the understanding of the individual's strengths and needs. o Psychiatric evaluations were detailed and their overall quality was good, although they did need to better identify the particular behavioral characteristics of the psychiatric disorders that were diagnosed. However, at the time of the compliance tour, only about 60% of individuals who needed psychiatric assessments had received them. o Review of MOSES and DISCUS forms showed that they were done correctly, and they were reviewed in a timely manner. DISCUS forms were not signed by the psychiatrist to document review and consideration.	
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.	Diagnoses were consistent with diagnostic criteria. However, individuals showed significant change in status without thorough evaluation to identify possible causes. For example, people who had changed from walking independently to lack of walking and use of wheelchair did not have evaluations of musculoskeletal conditions or health conditions that might cause significant pain. Therefore, it was not clear that diagnoses were complete and were updated as an individual's functional or health status changed.	N
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.	Treatments and interventions were not always timely or based on adequate assessment. • Functional assessments of behavior did not meet current standards. • The PNM (NMT) Team met regularly but did not meet timely to address change in status, assessment, clinical data and monitoring results. Based on a review of 19 individual records, documentation supported that the PNM Team did not meet regularly to address change in status, indicators of increased risk, clinical data and monitoring results. Assessments that were occurring outside of the annuals were merely observations and were not detailed enough to establish root cause or direct future treatment and therefore cannot be considered an assessment. Individual examples of where the PNM Team did not meet regularly to address change in status, assessment, clinical data and monitoring results included: o Individual #84 was diagnosed with aspiration pneumonia on 5/21/10. There was no evidence of a review by the PST to discuss the incident or assessment to determine cause of the event or to determine if a return	N

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		to oral intake was a possibility. o Individual #439 was diagnosed with aspiration pneumonia on 7/5/10. There was no HST or PST response to the incident. o Individual #223 was diagnosed with aspiration pneumonia on 1/14/10. No assessment was conducted post incident to fully determine swallow function nor was there evidence of team review o Individual #436 was diagnosed with aspiration pneumonia on 2/19/10 and 7/4/10. There was no evidence of assessment or investigation as to the root cause of the incident. There was also no evidence that the PNM team met to discuss the issue. o Individual #217 had a choking event on 7/13/10. There was evidence that OT observed a medication pass and mealtime but there was no evidence of follow up beyond the observation. There is also no evidence of a comprehensive oral motor assessment to determine if there was a decline in swallow function. • There was lack of congruency between Strategies, Interventions, and Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. Congruency was not noted with regards to Oral Motor/Swallowing or head of bed elevation as it is unclear as to what the rationale or justification was for multiple dining strategies or positioning interventions. o Individual #661 should have solids and liquids alternated. There was no description as to what swallowing issues this strategy addressed. o Individual #661 head of bed should be elevated but there was no indication of assessment or why the stated degree of elevation was appropriate. o Individual #251 should be offered drinks at the beginning of the meal. It is unclear as to why this intervention is needed. • None of the 17 Communication Assessments reviewed addressed the generally required areas of: o Verbal and nonverbal skills, o Expansion of current abilities, o Development of new skills. and o Whether the individual requires direct or indirect Speech Language services. Furthermore, none indicated individuals identified with severe expressive/receptive language did not have AAC investigated and assessed. • Psychotropic medication should be linked to relevant behavioral symptoms of the psychiatric disorder being treated. This could not be demonstrated. There was the appearance that psychotropic medications were prescribed primarily	

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		to control aggressive and self injurious behavior, and not for symptoms of a psychiatric disorder.	
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.	Use of clinical indicators of efficacy was variable. The Facility provided no descriptions of clinical pathways or guidance on specific indicators to guide clinicians and PSTs. The Facility is considering developing health care protocols to guide provision of services. Numerous examples demonstrated lack of use of clinical indicators of efficacy. • While PNMPs were reviewed at the PSP, there was not a system in place that clearly monitored the effectiveness of the plan by tracking the occurrence or absence of triggers associated with physical and nutritional decline. Many PNMPs had these indicators listed but there was not a method in place that collected this data for review. A process was not in place that promoted the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. • The monitoring team was concerned about the substantial weaknesses in behavior data. Despite such concerns, there was not any routine assessment of the actual quality of behavior data. Except in isolated cases that were verbally reported, there was no attempt to measure data reliability or interobserver agreement (IOA). Furthermore, when data were graphed to make behavioral changes more visible for timely decisions, , there was no indication on the graph of when the event occurred. Without such indicators, it was very difficult to identify the relationship between behavior, treatment effects and confounding variables. • The process of generating a meaningful medication treatment plan can be more complex than is immediately evident. For example, once the psychiatrist has selected a medication and has identified the desired effects of the medication, the psychologist and psychiatrist must select measures which will be used to evaluate how this will be measured. There was discussion of appropriate clinical indicators for pharmacotherapy and a few good examples but clinical indicators were not yet used routinely and effectively. • Indicators of functional decline did not lead to discussion or further analysis of the cause of decline, to the relation of such decline to behavioral and other concerns, or to consideration of alternative treatments and interventions.	N
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of	Issues related to health status were often not identified as significant and reported for timely action. For example, functional decline was not evaluated thoroughly. A systemic and important issue at the Facility is the lack of integration of health care services into the team process. Clinicians depend on direct care and nursing staff to report clinical changes and concerns but they are not aware of staff limitations to	N

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	individuals.	appropriately assess clinical signs. The Nursing Summaries for the most part contained more lengthy historical data but failed to analyze the data to clearly identify the individuals' health status related to each nursing diagnosis listed in the assessment section or the effectiveness of the related HMPs. Therefore, it was not possible to adequately determine if the individuals' health status related to their nursing diagnoses were progressing, maintaining, or regressing. Nor did the Nursing Summaries compare the individuals' health status from quarter to quarter as related to progress toward their measurable goals and objectives. A positive exception to this is that Braden Scale skin risk assessment was completed on each Annual and/or Quarterly Nursing Assessment. A process was not in place that promoted the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.	
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.	There were numerous examples of treatments and interventions that were not modified in response to clinical indicators. These can be found in many provisions. Furthermore, as indicated in several provisions, use of clinical indicators such as behavioral data, illnesses such as aspiration pneumonia, and signs of difficulty in swallowing did not lead to timely action.	N
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.	The new PSP policy and procedures are a step toward implementing clinical services that are integrated among clinical disciplines as well as being part of an overall PSP. Well-defined procedures for monitoring and coaching could enhance and speed up implementation. No other policies were provided by the Facility that required or promoted implementation of the provisions of this Section. Per report of the Facility, clinical policies and procedures are undergoing revision. As indicated throughout this report, integration of clinical services was not yet routine throughout the Facility, but procedural steps such as joint committee meetings and attendance of clinicians at planning meetings had begun.	N

Recommendations:

1. As part of development of health care protocols and clinical pathways, identify possible clinical indicators that can guide clinicians as they develop health care plans and objectives. Each discipline should review national standards to identify clinical indicators that could be selected.
2. Complete revision of policies regarding implementation of integrated services and follow these revisions with staff training on the policies and on how to carry out integrated planning.

3. Treatment plans and PSPs should include information on the clinical indicators to be monitored for specific treatments and interventions.
4. At PSP planning meetings and other treatment review meetings, reference to clinical indicators should be routine as a part of planning interventions, and documentation of decisions should reflect how those decisions were affected by this information.

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:** 1. RSSLC Plan of Improvement (POI) 5/17/10 2. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10. 3. RSSLC Policy I.8 Health Status Team Guidelines(10/12/09) 4. RSSLC Policy I.15 Actions Following Choking Incident (4/29/03) 5. RSSLC Policy I.19 Responding to Weight Loss/Gain (2/11/10) 6. RSSLC Policy D.23 Using Bed Rails (3/16/06) 7. RSSLC Policy D.25 Completing/Routing Fall Evaluation Form (9/7/05) 8. RSSLC Policy E.2 Crisis Intervention (5/1/03) 9. DADS At Risk Policy 006 (8/31/09) 10. Samples of completed Health Risk Assessment Rating Tool 11. Nursing Care Plan to mitigate/manage risk for Individuals #84 and #586 12. Record reviews of Individuals #7, #51, #57, #84, #99, #107, #146, #217, #223, #251, #324, #378, #403, #436, #439, #465, #508, #551, #557, #571, #586, #621, #634, #661, #755, #765, and #771 13. PSP /PSP Addendums and Consent Form for Positive Behavior Supports During an Active Treatment Program with attachments for Individual #448 **People Interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. Gary Sandler OTR, Director of Habilitation Services 3. Wilma Parker RN 4. Tran Quan, DO, Director of Medical Services 5. William Eckenroth, PhD, Director of Behavioral Services 6. Carol Agu, QMRP Consultant 7. Six Direct Care Professionals **Meetings Attended/Observations:** 1. Annual PSP for Individuals #358, #500, #747, and #621 2. Human Rights Committee (HRC) meeting 10/28/10 3. 10/29/10 Unit Morning Meeting at Rio Grande 4. Incident Management Team meeting 10/25/10. 5. Meal observations on Trinity, Leon, and San Antonio
	Facility Self-Assessment: The RSSLC POI indicated lack of compliance with all provisions of this section of the SA, pointing out that the facility is expecting a new policy from DADS addressing a new risk assessment process. The current DADS policy, even if followed by the RSSLC, did not correctly identify individuals who are at risk according to specific objective clinical indicators. This resulted in the absence of, or significantly deficient, plans for risk mitigation.

	Summary of Monitor's Assessment: The deficiencies in the at risk system described in the baseline report will continue until a new system is developed and implemented. These deficiencies are primarily the lack of objective criteria from which to assess risk which resulted in high risk individuals, or individuals at high risk in one or more assessment areas, not being rated high risk and, therefore, not likely to receive the intensity or frequency, of treatment needed to mitigate risk. Some examples are provided in I1 and I2 to illustrate this ongoing problem. The monitoring team reviewed a comprehensive list of risk ratings for each individual living at the RSSLC, using multiple assessment descriptors, and found only two individuals who were rated as high risk, each for one assessment descriptor. While the facility waits for additional policy guidance from DADS it needs to improve the use of the current system as best it can. The monitoring team identified, through its sampling, many individuals who should have been assessed at high risk and were not. As a result services and supports for these individuals were not necessarily targeted at priority health and safety concerns.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The RSSLC POI reported noncompliance with this provision of the SA and the monitoring team concurs. The current DADS policy, even if followed by the RSSLC, did not correctly identify individuals who are at risk according to specific objective clinical indicators. This results in the absence of, or significantly deficient, plans for risk mitigation. The deficiencies in the at risk system described in the baseline report will continue until a new system is developed and implemented. These deficiencies are primarily the lack of objective criteria from which to assess risk which results in high risk individuals, or individuals at high risk in one or more assessment areas, not being rated high risk and, therefore, not likely to receive the intensity, or frequency, of treatment needed to mitigate risk. The monitoring team reviewed a comprehensive list of risk ratings for each individual living at the RSSLC, using multiple assessment descriptors, and found only two individuals who are rated as high risk, each for one assessment descriptor. Individual # 586 was assessed at high risk because of chronic respiratory infections. Individual #84 was assessed at high risk because of GI concerns. Every other individual living at the RSSLC was assessed as either medium or low risk in every assessment category. The monitoring team identified, through its sampling of records and observations, many individuals who should have been assessed at high risk and were not. As a result services and supports for these individuals were not necessarily targeted at priority health and safety concerns. For example: • Individual #436 had multiple pneumonias over the past 8 months but was listed as being only at a moderate level of risk. • Individual #439 had chronic constipation, GERD and a history of aspiration pneumonia within the last 3 months but was listed as being at a low risk. • Individual #557 had a choking event on 9/23/10 but was listed as low risk.	N

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		• Individual #755 had a choking event on 9/3/10 but was listed as low risk. • Individuals #661, #106, and #169 all had fecal impactions within the last 12 months but all were listed as being at a low risk of constipation As noted there were only 2 individuals identified as being assessed at high risk. Based on the characteristics of the individuals living at RSSLC, and the observations conducted by the monitoring team, this number did not accurately represent those who are at risk. Additionally, the two individuals who were identified as high risk as were not provided with individualized nursing care plans (NCP) that addressed the risk. For example: • Individual #586's NCP refers to her as a him at times and referenced her as eating orally when she receives enteral nutrition. The NCP also was vague at times and did not provide detailed information regarding frequency of vital signs and lung sounds. • Individual #84's NCP did not provide detailed information regarding head of bed elevation, frequency of vitals and/or lung sounds. Nineteen of 19 records reviewed did not accurately identify individuals who are at an increased risk of physical and/or nutritional decline. In many of HRC forms the Risk vs. Risk statement did not address psychotropic medication risk at all, but simply compared the risks associated with the overall behavioral program, versus leaving the individual without treatment. Plans reviewed did not address directly the risks of medication treatment, namely the side effects of the medications. Individual #448 had numerous medical conditions, including congenital heart malformations, heart valve regurgitation and a pacemaker, that could result in severe injury or death should the individual be subjected to physical exertion or distress. For these reasons, the application of any physical or mechanical restraint should have been attempted with extreme caution or avoided altogether. Despite these risks, the Facility failed to implement or follow the necessary precautions. The PSP Addendum that addressed restraint did not address cardiac 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 services and supports after an	Assessments were not routinely done in response to a change in health or behavioral status. Furthermore, the risk assessment process that followed DADS policy did not identify people at increased risk. Individual #448 had numerous medical conditions, including congenital heart malformations, heart valve regurgitation and a pacemaker, that could result in severe	N

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	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.	injury or death should the individual be subjected to physical exertion or distress. The PSP Addendum that addressed restraint did not address cardiac risk even though medical assessment had identified these conditions. Based on a review of 19 individual records, documentation supported that the PNM Team did not meet regularly to address change in status, indicators of increased risk, clinical data and monitoring results. Individual examples of where the PNM Team did not meet regularly to address change in status, assessment, clinical data and monitoring results included: • Individual #84 was diagnosed with aspiration pneumonia on 5/21/10. There was no evidence of a review by the PST to discuss the incident or assessment to determine cause of the event or to determine if a return to oral intake was a possibility. • Individual #439 was diagnosed with aspiration pneumonia on 7/5/10. There was no HST or PST response to the incident. • Individual #223 was diagnosed with aspiration pneumonia on 1/14/10. No assessment was conducted post incident to fully determine swallow function nor was there evidence of team review • Individual #436 was diagnosed with aspiration pneumonia on 2/19/10 and 7/4/10. There was no evidence of assessment or investigation as to the root cause of the incident. There was also no evidence that the PNM team met to discuss the issue. • Individual #217 had a choking event on 7/13/10. There was evidence that OT observed a medication pass and mealtime but there was no evidence of follow up beyond the observation. There is also no evidence of a comprehensive oral motor assessment to determine if there was a decline in swallow function.	
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	The RSSLC POI reported noncompliance with this provision of the SA and the monitoring team concurs. Based on a review of 19 individual records, documentation supported that the PNM Team did not meet regularly to address change in status, indicators of increased risk, clinical data and monitoring results. Individual examples of where the PNM Team did not meet regularly to address change in status, assessment, clinical data and monitoring results included: • Individual #84 was diagnosed with aspiration pneumonia on 5/21/10. There was no evidence of a review by the PST to discuss the incident or assessment to determine cause of the event or to determine if a return to oral intake was a	N

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	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.	possibility. • Individual #439 was diagnosed with aspiration pneumonia on 7/5/10. There was no HST or PST response to the incident. • Individual #223 was diagnosed with aspiration pneumonia on 1/14/10. No assessment was conducted post incident to fully determine swallow function nor was there evidence of team review • Individual #436 was diagnosed with aspiration pneumonia on 2/19/10 and 7/4/10. There was no evidence of assessment or investigation as to the root cause of the incident. There was also no evidence that the PNM team met to discuss the issue. • Individual #217 had a choking event on 7/13/10. There was evidence that OT observed a medication pass and mealtime but there was no evidence of follow up beyond the observation. There is also no evidence of a comprehensive oral motor assessment to determine if there was a decline in swallow function. For Individual #448, for whom restraints had been used periodically, the Consent Form and attachments identified numerous risks, including GERD, history of open chest surgery, pacemaker/vagal nerve stimulator, and prone to have subluxation of cervical spine. The PSP Addendum of 7/29/10, under Risk vs. Risk of Restraint, overlooked all that and stated, "The PST is aware of the numerous restraints but find it necessary due to [Individual #448] aggression towards self, others and environment." Risk was not addressed by the PST, even in a section of the form devoted specifically to consideration of risk.	

Recommendations:
1. While the facility waits for additional policy guidance from DADS it needs to improve the use of the current system.
2. DADS should finalize a new statewide policy on risk assessment. Development of criteria should involve getting recommendations and review from clinicians at the SSLCs and RSSLC.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken To Assure Compliance:** **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI) 5/17/10 2. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10 3. Comprehensive reviews of the annual Personal Support Plan (PSP), Positive Behavior Support Plan (PBSP) and PBSP addenda, psychology and psychiatry evaluations, psychiatry clinic notes, monthly psychology notes, consent forms for psychotropic medication and Human Rights Committee (HRC) reviews for medications plans, quarterly nursing reviews, quarterly drug regimen reviews(QDRR), annual pharmacy reviews, neurology consults, sedation care plans, DISCUS forms, MOSES forms, EKG, chemistry and hematology labs, client injury reports for the following individuals: #041, #060, #101, #152, #174, #193, #199, #213, #267, #315, #320, #346, #347, #429, #439, #455, #465, #583, #647, #740, #747, and #750 4. Psychiatry evaluations for the following individuals: #008, #025, #146, #219, #325, #448, #473, #503, #530, #531, #585, #618, #630, #636, and #798 5. Chemical restraint checklists, behavior incident reports, progress notes related to restraint episodes, restraint reviews, post restraint RN/LVN physical evaluations, emergency restraint debriefings, PSP addenda related to episodes of chemical restraints for the following individuals: #005, #100, #137, #140, #160, #199, #267, #315, #328, #429, #523, #558, #721, and #756 6. Dental Support Plans (DSP) and Medical Support Plans (MSP), PSP addenda/HRC review of those plans, program implementation records, medication orders related to the pre-treatment sedation medication orders, integrated progress notes and nursing monitoring notes related to the pre-sedation treatment for the following individuals: #076, #138, #140, #161, #167, #328, #439, #508, #523, and #555 7. RSSLC procedure J11: Behavior Intervention: Using Sedation for Medical /Dental Appointment/Behavioral Symptoms 8. RSSLC procedure J3: Implementing Dental Support Treatment Support Plan 9. RSSLC Behavioral Incident Review (BIR) form 10. RSSLC Nursing form "Medical Monitoring of an Episode of Acute Illness/Sedation **People interviewed:** 1. William Eckenroth, PhD, Behavioral Services Director 2. Carol Heath, DDS, Dental Director 3. Tran Quan, DO, Director of Medical Services 4. Michael Shatz, Pharm D., Clinical Pharmacist III 5. Larry Sanxter, MS, Psychologist V 6. Elizabeth Ohiku, MD, Staff Psychiatrist 7. Hermant Patel, MD, Contract Psychiatrist 8. Dominic Joseph, MD, Contract Psychiatrist 7. Amina Abdulla, MD, Staff Psychiatrist 8. Alice Brunner, RN, Staff Nurse

	Meeting Attended/Observations: 1. Medical morning staff meeting, 10/27/10 2. Pharmacy and Therapeutics Committee(P&TC) meeting, 10/27/10 3. HRC meeting 10/28/10
	Facility Self-Assessment: The Facility reported that it did not yet comply with any of the provisions of this Section. Many of the comments on status in the POI described that psychiatrists were not able to schedule enough time to participate in all procedures specified in the POI. Many of the comments on status also stated that review of existing documentation indicated additional review/reporting procedures were needed to insure that the standards would be met. The monitoring team was encouraged to learn about the very recent hiring of two staff psychiatrists; this should resolve the time allocation issues. The monitoring team learned during the tour that seven Facility work groups had formed to address issues related to the review/reporting procedures. However, the work of these groups is at an early stage.
	Summary of Monitor's Assessment: Psychiatric care was provided for about 40% of the individuals who lived at RSSLC. Many of these individuals did not have the psychiatric evaluations that were required by the Settlement Agreement (SA), their Personal Support Teams (PST) had not properly considered which modalities of treatment best addressed their behavioral healthcare needs, and their medication treatments improperly targeted disruptive behaviors such as aggression and self injury, rather than specific symptoms of a diagnosed psychiatric disorder. During the period since the baseline tour, the Facility leadership responded to the need to expedite the process to have psychiatric evaluations in place for all individuals who received psychiatric care. It did so by adding a second psychiatric contractor to the evaluation project. At the time of the compliance tour, about 60% of individuals who needed psychiatric assessments had received them. The evaluations were detailed and their overall quality was good, although they did need to better identify the particular behavioral characteristics of the psychiatric disorders that were diagnosed. The Facility leadership also responded to the need to better integrate psychiatry into PST functions: In the past the Facility relied heavily on after-hours contractors who could not attend PST meetings. The Facility has now hired two staff psychiatrists, who should be available to participate more fully in the Personal Support Team (PST) process. Both psychiatrists started to work at the Facility just prior to the monitoring team's tour. The team inquired during the tour about the absence of the medication treatment plans that were required by the SA. The monitors were informed that several Facility work groups have formed, and that these will address SA requirements related to behavioral healthcare. Unfortunately, the process was at an early stage and no specifics were available for review. Three ongoing Facility wide programs were reviewed. A program that provided treatment to minimize the need for pre-treatment sedation was in place and was assessed to be generally strong, but measures to assess for treatment efficacy had not yet been developed. A required process to track psychiatric

	polypharmacy was in place, but a needed component that monitored efforts to reduce unnecessary polypharmacy was not. A required Facility wide process for tardive dyskinesia screenings was in place, but a needed process that identified and monitored individuals with positive screenings was not. The Facility achieved substantial compliance with requirements of the SA provisions that related to psychiatrists' qualifications and psychiatric staffing levels, and the SA provision that required campus-wide screening for psychopathology.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The Facility employed five psychiatrists. Dr. Rafael Guerrero was a contract psychiatrist who conducted two day-long psychiatric clinics twice per month. Drs. Hermant Patel and Dominic Joseph were contract psychiatrists whose recent responsibilities focused on psychiatric evaluations of individuals who lived at the Facility and who received psychiatric care. Drs. Amina Abdulla and Elizabeth Ohiku were staff psychiatrists. They had joined the psychiatric group just prior to the tour of the monitoring team, and their responsibilities were not yet fully defined. The credentials of the psychiatrists met the requirements of the SA.	SC
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	The 22 clinical records selected for comprehensive review were examined for the presence of a psychiatric evaluation. They were located in fifteen of the records. Records that did not have evaluations were for Individuals #583, #647, #347, #101, #213, #320, and #747. All evaluations reviewed met the requirements of provision J2. The Director of Clinical Services informed the monitoring team that across the campus, evaluations had been completed for 94 individuals out of the 163 individuals who received psychiatric services. Since about 40% of the individuals did not have psychiatric evaluations, the Facility was not yet in substantial compliance with the requirement of this provision, but it was on track to achieve that status.	N
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and	The 22 clinical records selected for comprehensive review were examined. Several of the requirements of provision J3 were met: Individuals treated with psychotropic medications had treatment plans and they had working psychiatric diagnoses. Also, there were no indications that medications were prescribed for the convenience of the staff, or as punishment. However, the guidelines for Provision J3 guidelines also specified that the psychotropic medication should be linked to relevant behavioral symptoms of the psychiatric disorder being treated. This could not be demonstrated. The report that followed the baseline tour of the monitoring team noted that in many of the records, there was the appearance that psychotropic medications were prescribed primarily to control aggressive and self injurious behavior, and not for	N

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	effective immediately, psychotropic medications shall not be used as punishment.	symptoms of a psychiatric disorder. Examination of the clinical records listed above, including records of recently prescribed medications, confirmed the monitoring team's initial impression. The matter of the proper linkage of medications to symptoms and diagnoses is a focus of Provision J13, and case-by-case reviews of the ten new medication plans are provided later in this report, under the discussion of that provision. Following the baseline tour the monitoring team recommended that particular attention should be given to psychotropic medication use, when the same target behavior was identified as both a symptom of psychiatric illness and also a response to environmental factors. The Facility stated in the POI that work groups have been established to review and revise procedures. The Director of Behavioral Services informed the monitoring team that several workgroups had started to meet, but that the workgroups were not at a point where detailed plans for improvement could be meaningfully reviewed.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	During the six months that preceded the compliance tour of the monitoring team, oral pre-treatment sedation was given before dental procedures 201 times, and oral pre-treatment sedation was given before elective medical procedures 120 times. Use of pre-treatment sedation was guided by RSSLC Procedure J11, *Behavior Intervention: Using Sedation for Medical /Dental Appointment/Behavioral Symptoms*. Efforts to minimize the need for pre-treatment sedation at the Facility were guided by RSSLC Procedure J3, *Implementing Dental Support Treatment Support Plan.* At the time of the tour, DSPs were in place for 267 individuals, and MSPs were in place for 120 individuals. The monitoring team met with Mr. Sanxter, Dr. Eckenroth and Dr. Heath, to review how clinicians at the Facility determined that pre-treatment sedation was needed, and to review the process used to develop Dental Support Plans (DSP) to help individuals become more comfortable with procedures, in order to minimize or eliminate the need for the pre-treatment sedation. The following items were discussed: 1. <u>Determination of the need for pre-treatment sedation for dental care</u>: Pre-treatment sedation was determined to be necessary if an individual experienced repeated episodes of behavioral difficulty during dental visits, and the difficulties were of sufficient magnitude to preclude participation in the procedure. The difficulties were documented in a Behavioral Incident Report (BIR), typically by Dr Heath. The BIR form was reviewed during the meeting. Items on the form allowed a good reconstruction of what the difficulties had been. These included designations of where the difficulty occurred (e.g. dental clinic, reception room, and hallway) and what the nature of the problem had been. Check-off boxes were provided for about 25 common scenarios (did not come, would not come in, slid out of chair, verbal abuse, bit toothbrush, grabbed instruments, grabbed staff/ hitting kicking, etc). Dr. Heath	N

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		explained that before pre-treatment was determined to be necessary, the individual was rescheduled several times, in the hope that sedations would in the end not be needed. If following repeated efforts the difficulties could not be overcome, Dr. Heath and her staff determined that pre-treatment sedation was needed. This determination did not involve PST review and decision. The PST was notified of the need for sedation. 2. Desensitization programs: Once the dentist determined that that pre-pretreatment sedation was needed to successfully complete the needed procedure, an individualized psychological program for desensitization to dental procedures was developed. The purpose of such programs was to decrease/eliminate the need for pre-treatment sedation. Many times, but not always, the core of the desensitization program consisted of gradual familiarization with the dental clinic and apparatus. Since much of the desensitization work took place in the dental clinic area, the dental suite area was reserved for one afternoon each week for the administration of dental desensitization protocols. Dental clinic staff provided most of the care in the dental suite itself. Psychologists and Direct Care Professionals (DCP) provided additional care, mostly on the individual's home and in the process of bringing the individual to the dental suite. Depending on the individual's circumstances, acclimatization could be limited to sitting in the waiting area or might include walking into the dental suite itself, or sitting in the dental chair. In many cases other elements for desensitization were used. For example, some individuals were not willing to go to the dental suite. In such cases psychologists worked on the home unit providing desensitization services, or perhaps worked with the individual to be willing to accept leaving the home and walking toward the dental clinic area. To provide services to individuals who might be willing to sit in a dental chair, but not in the dental clinic, an unused dental chair was given to the psychology group by the dental clinic for use in such procedures, It was placed in a different area of the campus, and it was used in a similar manner to the way that the dental chair was used in the clinic itself. A characteristic DSP was the one developed for Individual # 555. It consisted of 10 steps which were: Methodology: 1. Remains calm when told "you're going to the dentist" 2. Leaves home to go to the dentist 3. Gets in the vehicle or goes in the right direction 4. Enters the DPC (dental) building	

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		5. Enters waiting room 6. Sits in the waiting room for 1 minute 7. Follows the staff into the dental office 8. Stands until asked to sit in dental chair 9. Walks to the dental chair 10. Sit in the dental chair for 10 seconds <u>Objective:</u> By (date specified, the individual) will go to and stay for a dental procedure. For some programs, the focus was on dental brushing. For example a 14 step plan for Individual #167 consisted of walking to room, sitting in reclining chair, opening the mouth, allowing staff to insert a toothbrush, etc. For Individual #439 the procedures were tailored to the fact that the individual required a wheelchair. 3. <u>Development/approval of the DSP</u>: A psychologist who was familiar with the individual took the lead in the development of the DSP. After completion of the psychologist's work, the program was forwarded to the Qualified Mental Retardation Professional (QMRP). The QMRP then called a meeting of the PST, during which the program developed by the psychologist was reviewed and additional comments were provided by PST members. The QMRP next codified the plan as an addendum to the Personal Support Plan (PSP), and it was submitted to the HRC for review and approval. In parallel, consent was obtained for use of the medication proposed for pre-treatment use. The consent was obtained and submitted to HRC for review in the usual fashion, as described elsewhere in this report. 4. <u>DSP implementation:</u> Following HRC approval, the DSP plan was put in place. Each time a session was held, data-sheets were filled out. These tracked the individual's success for the particular session. This was typically done by way of check-offs for participation of the individual and for his/her success for any given step of the procedure. Comments were included if any step of the trial was not successful. 5. <u>Demonstration of need for continuation of the DSP:</u> Mention of the dental support plan was made in the annual PSP, and the plan was evaluated each year for continued need. Dr. Heath stated that at least once per year the client was offered a dental procedure without pre-treatment sedation. If the procedure failed, a new BIR was generated. As a practical check on the need for continued utilization of the DSP, Dr Heath required at least one BIR per year, to serve as an indication that continued pre-treatment was needed.	

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		6. Procedures for pre-treatment sedation for medical procedures. Overall procedures for pre-treatment sedation for medical procedures (for example, medical procedures such as colonoscopy, medical appointments that included physical exams or tests like EKGs or bone scans) were similar to procedures for dental pre-treatment, with the difference that the determination that pre-treatment sedation was needed was made by medical, not dental, providers. Once identification was made, procedures for the development of the MSP were similar to DSP, as outlined in steps 3-5 above. 7. Medical monitoring for safety during pre-treatment sedation: Procedures for medical monitoring for safety during the pre-treatment-sedation period were reviewed in a meeting with Alice Brunner, Registered Nurse (RN). Medication orders for the sedative were written by Dr. Heath for dental procedures and by primary care physicians (PCP) for medical procedures. The dose of Ativan for dental pre-sedations varied from 1 mg to 4 mg. In the case of medical pre-treatment sedation a variety of agents was used including various benzodiazepines and occasionally other agents such as Olanzapine. Safety monitoring was by RN's following procedures spelled out on a form titled *Medical Monitoring of an Episode of Acute Illness/Sedation.* For example this form was filled out for Individual # 523 on 05/18/2010. Monitoring was initiated at 07:15 am, and the frequency of monitoring was established at every 30 minutes for 24 hours. General instructions for care were to assist with activities of daily living, to use wheelchair when out of bed, to monitor for shortness of breath and to direct to quiet/rest during the day. On that day 30 minute checks were done for the full 24 hours, but provisions were available for the RN to discontinue checks, per Health Care Services procedure 1.16 which guided the monitoring for use of sedation. The cases in which higher doses of Ativan were used (4 mg, for individual #167 and #523) were examined to verify that nursing monitoring included vital sign checks, and they were. To review overall Facility practices for documentation related to dental pre-treatment sedation, the monitoring team reviewed documentation related to dental pre-treatment sedation for Individuals #555, #523, #138, #161, #508, #076, and #167. These individuals were selected from a list provided by the Facility which contained the names of individuals who had received dental and pre-treatment sedation and the dates of the procedures. The seven individuals were the first seven names on the list, for which the list specifically stated that the procedure in question was dental. When there were multiple dates for the same individual, only the first listing was selected. For each individual the monitoring team requested DSP program documentation, related PSP/HRC documentation, medication orders for the pre-treatment sedation, and nursing notes and progress notes from the day of the dental clinic visit that clarified the medical monitoring for safety that had taken place. In all seven cases the monitoring team was provided with a DSP that outlined the details of the plan, and a data record sheet, that demonstrated that the	

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		program was implemented. Consent for the medication in question was provided in each case, as were the orders for the medication and notes that showed the nursing support that was provided. PSP documentation of the plans and HRC review for the procedure in question was provided for only three individuals. In three additional cases PSP/HRC documentation was provided for very similar procedures, (such as a plan for intravenous sedation) instead of the documentation requested. However, many documents presented to the monitoring team as dental support plans did not meet the requirements of policy J.13. Most were limited to tooth brush tolerance programs. From document review there did not appear to be any standardized, policy directed, methodology for the development of medical support plans to address use of pretreatment sedation. Three additional clinical records were requested for individuals who had medical pre-treatment sedation. These were for Individuals #140, #328, and #439.The selection process was similar to the one process noted about for dental pre-treatment sedation. It was based on the list provided by the facility of medical procedures for which pretreatment-sedation was used. One date was selected for each individual, and only one individual was chosen for a given type of procedures (EKG, bone scan, etc). Consent for medication/ HRC review was provided for all three individuals and data record sheets were provided for two. Medical Support Plans were not provided. In the meeting with Dr. Heath, Dr. Eckenroth, and Mr. Sanxter, the monitor inquired how the Facility monitored whether the DSPs were successful in achieving their goal of a reduction in the need for pre-treatment sedation. Dr. Heath stated that it was her impression that in recent years the percentage of individuals coming to dental clinic who needed pre-treatment sedation has dropped, and that for some individuals, lower doses of medication were necessary. She emphasized her efforts to use pre-treatment sedation only when needed, and emphasized that she used the lowest dose possible. Dr. Eckenroth shared that the Facility was already in the process of developing a dental sedation data base. All participants in the meeting agreed that measures of efficacy for dental sedation were needed, and that during the coming months the Facility would provide specifics for such measures. Presence of appropriate efficacy data would be a necessary component for a finding of substantial compliance with the requirements of the SA. The meeting in question focused on dental sedation and the monitoring team did not focus on the issue of medical sensitization. However, Provision J4 addressed pre-treatment sedation for both routine medical and dental care. Accordingly, the Facility is encouraged to consider how it might document efficacy of both medical and dental desensitization programs.	

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J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	Psychiatric staffing at the Facility expanded, with the recent employment of Drs. Ohiku and Abdullah as full time staff psychiatrists. At the time of the tour Dr. Abdullah had worked at the Facility only for several days, and Dr. Ohiku had been employed for several weeks. Dr. Guerrero worked as a contractor for about 5 hours per week. His primary assignment was to conduct the twice monthly psychiatric clinics that had been in place for many years. He worked as a consultant and during his clinics he provided written recommendations for care. The orders for medication were then written by Facility primary care physicians. Dr. Guerrero was readily available for telephone contact with the Facility when his input was needed. Dr. Joseph worked for the Facility as a contractor for about 12 hours per week, and Dr. Patel worked as a contractor for the Facility for about 10 hours per week. The work of both focused on providing detailed psychiatric evaluations. Despite her short tenure at the Facility, Dr Ohiku started to develop her own psychiatric service and had primary responsibility for three individuals. The Director of Behavioral Services indicated that the Facility planned to continue to rely on a combination of the staff psychiatrists and contractors. The combined resources of about two and a half FTEs of psychiatric care provided a ratio of about one psychiatrist for 65 individuals. With the above in mind, the Facility employed or contracted with a sufficient number of board certified or board eligible psychiatrists to ensure the provision of services necessary for the implementation of the psychiatric section of the SA. The monitoring team will review whether this staffing actually ensures provision of services at future compliance reviews.	SC
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	During the six months since the baseline tour of the monitoring teaming team, RSSLC continued the process of completing psychiatric assessments for individuals who received psychiatric care. At the time of the compliance tour, assessments were in place for 94 of the 160+ individuals who received psychiatric care As identified in the baseline report, Dr. Eckenroth indicated that he had allocated Dr. Hermant Patel three to four weekly visits to complete a historical review of the individual and their records, prepare a detailed report, and meet with the PST to discuss to his findings, and with the individual's family and LAR as well, if they were available. Since the baseline tour, Dr. David Joseph joined Dr Patel in the effort to complete psychiatric evaluations for all the individuals who needed them. At the time of the compliance tour, Dr. Patel had completed 56 evaluations and Dr. Joseph had completed 33 evaluations. Drs. Jain and McManus, who are no longer employed by the Facility, had also been asked to complete assessments. Prior to their departures, Dr, Jain completed two evaluations, and Dr. McManus completed three. As a group, RSSLC psychiatrists' had completed	N

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		comprehensive evaluations on 94 individuals of the 160+ individuals who received psychiatric care at the time of the tour. To assess compliance with provision J6, the monitoring team requested and was provided with a list of the 94 individuals who received comprehensive evaluations. Ten evaluations were selected for each of the two current psychiatrists. The monitor requested that each fourth evaluation from an alphabetical list of completed evaluations be included, until the limit of 10 records per psychiatrist was obtained. In a number of cases selected records were pending dictation. In those cases another selection was made using the same method. The total sample of 20 evaluations was examined. The clinical records selected were for Individuals #008, #025, #060, #146, #199, #219, #267, #325, #630, #429, #448, #465, #473, #503, #530, #531, #585, #618, #636, and #798. The reports varied in length from five single spaced pages to eleven pages. The reports were most commonly seven to eight pages long. As mentioned in the baseline report, the evaluations identified the individuals in terms of their demographics, including their age, place of birth, marital status, whether or not they are a registered voter, any Court imposed restrictions, source of income, Social Security Number, Medicaid number, Medicare number, primary language, race, nationality, religion, legal status, competency status, whether or not an interpreter is needed, resuscitative status, burial arrangements, routine notifications required, primary correspondent and emergency contact, any restrictions, as well as approved visitors. The next section addressed the reasons for the evaluation. There was also a section on the reliability of the individual's self reporting. The sources of information were described, as well as the location where the psychiatric interview and examination took place. This was followed by a description of the chief complaint, the history of present illness, and current medications. Any specific allergies to psychotropic medications were identified. There was a lengthy past psychiatric and medical history section. A section devoted to prior medications listed the medications to which the individual has been exposed. However, these sections in the sample reviewed did not identify the maximum dosage of the medication, duration of the medication trial, and whether it was discontinued due to lack of efficacy or side effects. The family history was reviewed in detail, as was the individual's personal history, including data related to any school history, military history or legal history. The results of the most recent physical examination and laboratory tests were summarized. There was a comprehensive mental status examination. A section was also devoted to "Patient's and Family Strength," which was followed by a "Summary of Findings" that included the psychiatric diagnosis in the DSMIV-TR multiaxial format, as well as a brief comment about prognosis. The final section was entitled "Comprehensive Treatment Plan and Recommendations"; this section included not only a detailed discussion of the current psychopharmacological treatment, but also additional medical workup and laboratory testing that might be useful, including	

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		whether or not a Neurology Consultation would be helpful. There was also a request for collateral information that would help to clarify unresolved issues. These reports clearly met the standards set forth in the Settlement Agreement. Although the psychiatric evaluations that were done met the required standards, there were two areas where further improvement could help the Facility's efforts to come into compliance with other provisions from Section J of the SA: Sections J3 and J13 of this report emphasized that medication treatment should focus on observable symptoms of psychiatric illness, not only on general symptoms of distress such as aggression and self injury. But in many psychiatric evaluations done to date the degree of emphasis on aggression and self injury, at times at the expense of more specific symptoms of mental illness, may have resulted in a reduced ability to detect the effect or lack of effect of medication treatment. This matter was discussed during the tour with several of the Facility psychiatrists. One theme that emerged during those conversations is that in the process of retrospective analysis of long term treatment records, it was natural to gravitate toward symptoms that were well and repeatedly documented, such as aggression and self injury. But these are not the symptoms that are most helpful to formulate psychiatric treatment. As above, part of the psychiatric evaluation and reevaluation process that is underway was a detailed review of all available records. During reviews it would be helpful for the psychiatrists to search with care for evidence of more specific psychiatric symptoms, which may well have been present but may have been poorly documented. To further explore the degree to which information on psychiatric symptoms necessary for medication treatment plans was present in the records, a second analysis of the 20 selected psychiatric evaluations was performed. In this analysis the monitoring team examined each of the psychiatric evaluations for the presence or absence of recorded behavioral symptoms that were not related to agitation, aggression, self- injury and the various forms of program non-compliance. The symptoms were noted even if they were not prominently featured in the case formulation. In two cases, Individuals #267 and #199, Reiss screens had been requested by the monitoring team and their contents were also reviewed. In both those cases, additional behavioral symptoms that were relevant to the individual were identified. The results of the analysis were as follows: Case # | Psychiatric symptom/behavioral characteristic identified | Case # | Psychiatric symptom/behavioral characteristic identified # 267 | Motor hyperactivity, mood | #530 | Possible hallucinations, appetite,	

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			symptoms Reiss items: Euphoria, impulsive, overactive, sexual problem, social inadequacies		sleep, apathy,	
		# 199	Attention span and distractibility, mood symptoms including suicide threats, sleep difficulties Reiss items: crying spells, anxiety, overly sensitive, low energy, sleep problem, tiredness, confused thinking	# 60	Compulsive/stereotypy, history of attention related symptoms.	
		#630	Mood symptoms; depression with suicidality and overdose, auditory/command hallucinations, racing thoughts, thought control	# 531	Mood symptoms and sleep	
		# 008	Obsessive ideation, rumination, attention span issues	# 465	History of close head injury; inexplicable crying spells	
		# 473	Delusions with loose associations, perseveration and tangentiality, hyperactivity, pressured speech, depressed mood	#618	Psychogenic polydipsia, impulsivity, seeming compulsive behaviors	
		# 025	Neurovegetatative symptoms and refusal to eat	#325	Sadness, short attention span	
		# 146	History of hallucinations	#585	Mood lability, inexplicable crying spells, hyperreactivity	
		# 798	Hoarding behaviors, symptoms of depression including spending more time in bed, withdrawn, increasing crying spells; anhedonia, isolation, flat affect	# 636	Motor hyperactivity, sleep symptoms, repetition/stereotypy, dysphoric mood,	
		# 429	"possible psychosis" without elaboration but which is said to have responded to Zyprexa; history of sequelae of abuse and neglect; sensory hypersensitivity with	# 503	Cited medical cause for diagnosis of mood disorder secondary to medical condition may have resolved	

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		<table><tr><td></td><td>behavioral consequences</td><td></td><td></td></tr><tr><td># 219</td><td>Suggestions of behavioral responses to sensory hypersensitivity in the setting of either autism and/or PTSD related to abuse/neglect prior to admission</td><td>#448</td><td>Suggestions of characterological difficulties, mood lability</td></tr></table> A second area of relative weakness in the psychiatric evaluations done to date was the relative absence of discussion about diagnostic possibilities, including the possibility of no psychiatric diagnosis. Since many of the diagnostic reviews rely on reconstructions of past care it is important to keep all reasonable possibilities open. In summary, all evaluations reviewed met the standards of provision J6, although increased attention to the identification of behavioral symptoms relevant to the diagnosis would be helpful, as would a greater emphasis on differential diagnosis. Substantial compliance was not achieved, due to the fact that evaluations were not yet in place for many individuals.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric	The 22 clinical records selected for comprehensive review were reviewed for this component. This group included the five individuals who were admitted to the Facility since Jan 1, 2010. Completed Reiss screens were found in 18 clinical records, and the completed records included all five admissions. Completed Reiss screens could not be found in five clinical records. These were records for Individuals #060, #320, #429, #465, and #647. The monitoring team asked the Director of Behavioral Services about Facility plans to complete Reiss Screens. The Director indicated that a plan is in place for individuals to receive Reiss screens at the time of their annual meetings. All individuals admitted recently had Reiss screens and had psychiatric assessments. In all cases, individuals screening positive for psychopathology were already receiving such services. In other words, none of the Reiss screens done to date led to a new identification of psychopathology. The Facility was on track to complete the requirements of provision J7, and was in substantial compliance with the requirements of this provision.	SC

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	assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.		
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The 22 clinical records selected for comprehensive review were examined. Meetings were held with the Director of Behavioral Services, Staff Psychiatrists, and Contract Psychiatrists. In those meeting the topic of interdisciplinary integration between psychology and psychiatry was addressed. RSSLC psychologists and psychiatrists had a close working relationship. This was particularly evident in the twice monthly psychiatric clinics that were conducted by a part time psychiatric consultant. This clinic was the place where most of the decisions about psychotropic medication management were made. Prior to each clinic, psychologists (and other PST team members) prepared summaries of the current behavioral data, as well as a historical review of that data. Psychologists also provided a written summary spelling out their analysis of the individual's status; although this is a positive step and can be valuable for both diagnosis and selection of treatment, weaknesses in psychological assessment (including functional assessment) may have made these analyses less valuable than they could be. The psychiatric consultant then wrote a brief summary of the psychiatric diagnosis and mentioned any changes in the individual's status, and made recommendations for further changes in the psychotropic medication. With the above in mind, it was clear that there was considerable involvement of the psychologists in the process of the administration and prescription of psychotropic medication. Nonetheless, there were several factors which precluded meaningful integration of psychiatric and psychological treatments through combined assessment and case formulation, as required by provision J8. These were: • As reviewed in more detail under provision J13, data presented for consideration at the psychiatric clinics was heavily dependent on information collected by the psychologist for targets of psychological/behavioral interventions. To the extent that medication treatment plans existed, they relied on existing behavioral targets, even when these did not reflect the relevant behavioral symptoms of the psychiatric diagnosis. • By necessity, the very busy schedule – at least 25 individuals needed to be reviewed during each clinic – focused on matters of immediate clinical management. Understandably, the consultant did not have the time to undertake careful case analysis and case formulation. Certainly, neither he nor the Facility psychologists had the ability to reflect on the far more complex issues of combined interdisciplinary assessment and case formulation. The consultant's notes from the	N

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		clinic session reflected these realities. • As described under provision J6, the Facility decided over a year ago to have psychiatric assessments prepared for each individual who received psychiatric care. To date, 94 such assessments have been completed. However, these assessments were not done by the consultant who ran the psychiatric clinic, but rather by other psychiatric consultants, who could not attend the psychiatric clinic. Although the notes from the psychiatric clinic clearly indicate that the recommendations from the assessments were known and were considered, overall meaningful clinical integration between staff psychologists and the various contracting consultants was simply not possible. As the result of the above, the Facility was not in compliance with the requirements for this provision, which required combined assessment and case formulation.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	The 22 clinical records selected for comprehensive review were examined. Provision J9 required that the IDT and the psychiatrist should determine the best therapeutic approach for individuals who receive behavioral services. To do so, there were three requirements: • The team (including the psychiatrist) should determine the least intrusive/most positive interventions for the individual. • The team (including the psychiatrist) should determine which treatment modalities are most appropriate for the individual. • The team (including the psychiatrist) should make sure that treatment does not consist of psychotropic medication alone. <u>Least Intrusive most positive interventions:</u> Documentation that efforts were made to provide individuals with less intrusive/minimally restrictive interventions was found in many places in the charting process. For example, a consistent format was used by the Facility for the PBSP format. Section #2 of the Positive Behavior Support Plan (PBSP) addressed how the treatment choices were made to achieve less intrusive interventions. For example, in the PBSP for Individual #320 the following statement was made: *"Rationale for treatment methodologies selected: These behavior supports stress increasing her social interaction so staff may easily understand her needs and wants in the hope of reducing the need for protective restraints in the future. Through*	N

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		fading techniques, staff will encourage (the individual) to tolerate being without restraints, as she has become accustomed to them and actually prefers to have them in place." In the case of Individual #647 the rationale for the proposed behavioral intervention stated: *"The overall approach was determined by the functions of the behaviors and his reported reinforcers. An embedded preference was determined by the functions of the behaviors and his reported reinforcers. An embedded preference assessment process is incorporated to find activities for (the individual) that he has interest in, since there are few reported, with the hope of finding further reason for him to become engaged in productive activity.* *The interventions for problem behaviors utilize minimally intrusive procedures because he is usually redirected by prompting…."* In the case of Individual #429 the rationale for the treatment methodology stated: *"A differential reinforcement for alternative behaviors is being used for (the individual) as this is not perceived to be a restrictive procedure"* A focus on minimizing the degree of intrusion was present in the description of medication treatments as well. Section #4 of the PBSP addressed psychiatric treatment and each plan contained a "Medication Reduction Plan." These stated that consideration would be given to reducing or discontinuing medication whenever "problem behaviors" decreased by specified amounts and at least annually, during the individual's personal goals planning meeting. While the above citations demonstrate that PBSP plans were true to the intent of the SA, the process in place at the Facility did not meet the requirement that determinations would be made by the PST, including the psychiatrist. The intent of the SA requirement was that there should be a treatment planning session (or some other similar process) in which the psychiatrist was a full participant. Based on the information available to the monitoring team, such a process was not in place at the Facility at the time of the tour. <u>Determination of the most appropriate modalities of treatment:</u> Clinical records documented the rationale for the choice of behavioral treatment, for example in section #2 of the PBSP. Records documented the rationale for the medication treatment plans in both the HRC review of the new medication in the "justification" section, and in the PBSP in section #4, "Drugs for Behavior Management." The PBSP	

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		format also addressed the requirement in the provision to consider "other interventions," in addition to behavioral and medication treatments. This was done in section #3 of the PBSP, titled "Adjunctive Therapies." These statements were not sufficient to meet the requirements of the provision. First, as discussed in detail under provision J13, the rationales offered for medication treatment in both the HRC documents and the PBSP were far too broad and non specific to be meaningful. Second, as in the discussion immediately above, the PST and psychiatrist did not meet to discuss available treatment options. Accordingly, any determinations made in the PBSP and HRC documents were not properly evaluated by the required interdisciplinary group. <u>Determination that treatment does not consist of psychotropic medication alone:</u> Review of the 23 clinical records demonstrated that this requirement was met by the PSTs at the Facility: None of the individuals reviewed were treated with medication alone. As the result of the above, the Facility was not in compliance with the requirements for this provision, which required full involvement of the PST, including the psychiatrist, for matters regarding the selection of treatment modalities.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	Clinical records were reviewed for individuals recently prescribed new psychotropic medications. These were Individuals #41, #152, #174, #193, #199, #213, #429, #439, #647, and #740. In the records that were reviewed, risk/benefit analysis and discussions of alternative strategies were included in a number of places, including the *HRC Review of Added Psychiatric Medication*, that had a section for "*Risk vs. Risk Analysis*. In some HRC reviews the sections addressed the required areas. For example, the 08/26/10 HRC review for the addition of Zyprexa for Individual #429 stated: *"Less intrusive approaches previously attempted: PBS, New Safety Plans"* and *"Risk vs. Risk Analysis: The risk of not implementing the medication could result in an increase in self injurious behavior which would lead to a more restrictive setting. A possible risk of implementing the medication can be the various side effects associated with it."* However, in many of HRC forms the Risk vs. Risk statement did not address medication risk at all, but simply compare the risks associated with the overall behavioral program, versus leaving the individual without treatment. For example, the 08/26/10 HRC review for the addition of Wellbutrin for Individual #199 stated*:* *"The PBS includes procedures that pose a minimal risk for (the individual). The risk*	N

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		of implementing this PBS include(s) possible injury to (the individual), staff and others from the PMAB protective skills; or when these skills are done wrong or done late when aggression does occur. This PBS also includes prompting interventions in order to divert behaviors early in the behavioral change of inappropriate behaviors however under certain conditions it could bring about a full blown incident due to an increase in agitation. Similarly, the HRC review of 08/26/10 for Individual #193 stated: *"Procedures are included in the positive behavior supports to minimize the risk of injury to (the individual) or others. This positive behavior supports is in conjunction with psychotropic medication. The behaviors for which she is receiving psychotropic medication are considered harmful because they may interfere with active treatment, and limit access to less restrictive settings."* Neither of these plans addressed directly the risks of medication treatment, namely the side effects of the medications. In addition to the general requirement for risk/benefit analyses and consideration of treatment alternatives, the provision also required that the relevant considerations should be made by the PST, with participation of the psychiatrist, primary care physician and nurse. There was no documentation that the required discussions took place during the psychiatric clinics, the only time the psychiatrist was present. Additionally, some of the other required participants did not attend the psychiatric clinic. As a result the explicit requirements of the provision regarding who should participate in the decision making were not met.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to	The 22 clinical records selected for comprehensive review were examined. These included records of ten individuals who had recently been prescribed new psychotropic medications. The monitoring team reviewed minutes of the Pharmacy and Therapeutics Committee (P&TC) and Interdisciplinary Psychoactive Medication Prescription Review. This latter committee was described in the meeting minutes as "the interdisciplinary meeting for psychiatry, medical services, pharmacy, nursing and behavioral services to review poly-pharmacy, chemical restraints and sedation." The monitoring team also reviewed summary sheets prepared by the Director of Behavioral Services that identified the number of individuals receiving polypharmacy and the patterns of their polypharmacy regimens. The monitoring team met with the Director of Behavioral Services, with the clinical pharmacist and with four of the Facility psychiatrists, and attended a scheduled meeting of the P&TC.	N

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	the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	The materials and discussions confirmed that the Facility reviewed psychotropic medication practices in four ways: 1. Polypharmacy practices were addressed as "yes" or "no" item on the psychiatric clinic notes. There was no discussion of the potential interactions or implications of the polypharmacy. 2. Polypharmacy practices were addressed in the quarterly drug regimen reviews (QDRRs). These were prepared by the clinical pharmacist and they provided guidance to the clinicians based on lab values, drug levels, information about drug-drug interactions, pharmacodynamic and pharmacokinetic variables and the like. In the baseline report the monitoring team noted that these reviews were signed by the primary care physician and the clinical pharmacist, but not by the prescribing psychiatrist. This has not changed over the past six months. During the tour the monitoring team met with the clinical pharmacist and reviewed the need for the prescribing psychiatrist to review the QDDR. The clinical pharmacist noted that QDDRs will be sent to both the primary care physician and the psychiatrist. The clinical pharmacist also described his email communication with clinicians, about time sensitive matters. 3. The Facility had a committee that met monthly and discussed (amongst other things) polypharmacy. It was attended by the Medical Director and CNE, and by psychiatrists, psychologists, the clinical pharmacist, and dentist. Minutes of this committee were reviewed, and the work of the committee was discussed in a meeting with the Director of Behavioral Services. To date, the committee had addressed only general issues related to medication uses. For example, the group recently reviewed clinical guidelines for lithium use. 4. The Facility had a Pharmacy and Therapeutics Committee. Polypharmacy practices were not the focus of this committee, but issues of importance regarding drug interactions and related matters were included in its agenda. For example, at the recent meeting the clinical pharmacist reported that he had attended an annual psychopharmacology course in Austin, and he provided information from that course. This included information regarding possible teratogenicity of a widely prescribed antipsychotic, and discussion about the clinical implications of the new finding followed. During the visit the monitoring team reviewed printouts made available by the Director of Behavioral Services which gave a general indication of medication and polypharmacy practices at the Facility: • Of the 163 individuals who were prescribed psychotropic medications, 127 were prescribed antipsychotic medications; of these 118 were prescribed atypical antipsychotics, 12 were prescribed typical antipsychotics.	

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		• 17 individuals were identified as receiving polypharmacy: three were prescribed both atypical and typical antipsychotics, six were prescribed with two atypicals, five were prescribed two anticonvulsants for behavioral indications and three were prescribed two antidepressants. Deficiencies noted during the tour included the fact that the committee that reviewed polypharmacy has to date limited its work to a review of general topics. It has not yet started to monitor prescription practices, as outlined in the language of the provision. In addition, the prescribing psychiatrist is not a full participant in the QDRR process, and no information on tracking or trending of polypharmacy was provided to the monitoring team. While some Facility strengths were noted, for example the work of the P&TC, the Facility is not in compliance with the requirements of this provision.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The 22 clinical records selected for comprehensive review were examined. Alice Brunner, RN, an experienced nurse who was involved in the administration of the DISCUS forms was interviewed regarding details of DISCUS and MOSES administration. Review of MOSES and DISCUS forms showed that they were done correctly, and they were reviewed in a timely manner. Several of the nurses who do the DISCUS screening were trained in person by the individual who developed the tool. Videotaped trainings were also available at the facility. Procedures for administration of the DISCUS were reviewed. Nurse case managers administered the DISCUS per guidelines for the tool, and a system was in place to prompt the nurse for the need to complete a baseline DISCUS when new medication orders were written. The manner in which positive DISCUS findings (a new rating of 5 or higher; an increase of several points over previous ratings) were addressed was discussed. The monitoring team was informed notice to physician was made, often to the primary care physician and if necessary to the physician on call. The monitoring team found that the process of DISCUS and MOSES administration by nursing staff was satisfactory. The manner in which the resulting information was reviewed and the information utilized was not. First, the DISCUS forms should have been signed by the psychiatrist who was responsible for decisions about the individual's psychotropic medications. They were not. In addition, the Facility did not have a list of individuals found to have dyskinesia, on the basis of the DISCUS exams. In addition, the Facility did not have list of the names of individuals who were diagnosed with tardive dyskinesia on the basis of the DISCUS screenings. It is important for the facility to know who those individuals are; while there are clinical situations in which individuals with dyskinesia are properly treated with antipsychotic medications, such treatments should	N

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		receive particularly detailed reviews. Furthermore, it is essential to know whether people with scores indicative of tardive dyskinesia are receiving this diagnosis and whether people with signs indicative of tardive dyskinesia are being identified during routine screening. It is also important to be sure that individuals known to have dyskinesia have that diagnosis listed as part of their diagnosis of record. Prior to the tour, the monitoring team had requested information a list of individuals diagnosed with dyskinesia, and were informed that there was only one such individual, It is not clear that all individuals found to have dyskinesia on the basis of the DISCUS had that diagnosis added to the list of their clinical diagnoses.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	Provision J13 spelled out the requirement for medication treatment plans. Clinical records were reviewed for individuals recently prescribed new psychotropic medications. These were individuals # 41, #152, #174, #193, #199, #213, #429, #439, #647, and #740. Facility procedures for medication management were reviewed. During the review period, recommendations for elective new psychotropic medications were initiated by the consulting psychiatrist, during the twice monthly Psychiatry and Behavior Management Clinic. This clinic was often referred to as the psychiatry clinic. Over 30 individuals were often reviewed at each of those clinics. Individuals were scheduled to be seen in the clinic at least quarterly, and they were seen more frequently if it was needed. The clinic was typically attended by the psychologist who worked with the individual, the QMRP, and the nurse case manager. An extensive package of information was provided to the psychiatrist. The package included reports of the above professionals on the progress of the individual being reviewed. These reports were often accompanied by the professionals' recommendation for treatment. The consulting psychiatrist was also given copies of relevant lab reports, and copies of MOSES and DISCUS screens. QDRRs were provided to the consultant for pharmacy input. The consultant then examined the individual and dictated a short note containing treatment recommendations, including recommendations for new psychotropic medications. When such a recommendation was made, the psychologist prepared an Authorization Form for Psychotropic Medications in an Active Treatment Program. This form contained information regarding the purpose of the new medication that was proposed, the expected benefits of treatment with the medications, and side effects that could be associated with the new medication. As appropriate, the form was provided to the guardian/legally authorized representative or to the Facility director, and it served as the informed consent for use of the medication. Next, information about the new medication was presented to the HRC, as a document titled "HRC Review of Added Psych Medication." That form contained a program summary, a justification for the medication, a listing of less intrusive approaches previously attempted, a risk vs. risk analysis (essentially, a comparison of the risk associated with the	N

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		proposed treatment vs. the risk of the untreated problem), and a plan for eventual discontinuation of the medication ("plan to remove restriction/intrusive component"). Information on medication from the following sources was then added to the BSP: Each BSP for individuals taking psychotropic medications contained a section on psychiatric treatment, which listed the psychiatric diagnosis; the drugs used for "behavior management;" the date the medication was started; the doses/maximum daily dose; and potential side effects of the medications. The section ended with a brief statement called "Medication Plan" which outlined the continuing manner in which the medication would be used. In theory, the structure used at the Facility for documentation could have been sufficient to answer the requirements of J13 and the related provision J3, which defined what constitutes appropriate psychotropic medication use. As outlined in detail below none of the 10 programs reviewed did so. As a general matter, the most consistent problems noted were: • Most (nine of10) proposed treatment plans focused largely or exclusively on the reduction of the individual's aggressive and self injurious behaviors. As outlined in the agreed-upon guidelines for provision J3, appropriate use of psychotropic medication use should be linked to relevant behavioral symptoms of specific psychiatric diagnoses. In turn, proper identification of those symptoms would provide guidance as to the appropriate choice of medication. In contrast, irritability and resulting symptoms of disruptive behaviors are part of at least 19 different psychiatric disorders. Taken alone, symptoms of aggression to self or others are too non- specific to link meaningfully to a psychiatric disorder, to provide guidance about which psychotropics are the best choices, or to provide guidance as to the status of the disorder. • In several proposed treatments, the consulting psychiatrist provided details of his intent for treatment that was not carried forward to documents written by others, which spelled out the detail of the treatment plan. • None of the plans reviewed contained the elements required by provision J13 for psychiatric treatment monitoring: None outlined the measures that would be used to monitor psychiatric symptoms, and all relied only on data collected by the psychologists for identified problem behavior. As identified in the examples that follow, a limited number of psychological plans included some psychiatric data, but even in those plans the data on psychiatric symptoms was too limited to constitute a meaningful psychiatric treatment plan. Comments on specific plans are as follows:	

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		• Individual #41, diagnosed with autism and obsessive compulsive disorder (OCD), was seen in the psychiatric clinic, after he had been hospitalized, and had been lethargic. Two medications, clonazepam and Invega, had been held. The psychiatrist noted that the individual was reported to be doing better and on mental status exam, he was awake and not agitated. The psychiatrist recommended discontinuation of the two medications. There was no mention of a new medication. Informed consent was then obtained for Abilify, an antipsychotic medication. The consent identified the need for medication as "part of the behavior/psychiatric treatment program for (the individual) that has the diagnosis of obsessive compulsive disorder and autism that resulted in ongoing inappropriate behaviors." The consent did identify possible medication side effects. The HRC review form was not provided to the monitors. The PBSP which was in place stated that the plan for all medications was *"the PST will evaluate the response to psychotropic drugs at least monthly. Consideration will be given to attempting to reduce psychotropic medication once the behavioral objective of aggression and self injury are attained or at least once per year."* The behavioral tracking monitored for measures of self injury, aggression and rectal digging, but not OCD. From the documentation it was not possible to tell whether the medication was intended to treat symptoms of autism or OCD or to identify the relevant psychiatric target symptoms, and the documentation did not provide details regarding monitoring of any symptoms of OCD . The language about duration of treatment is too general to be meaningful and did not specify which of several medications (Seroquel, Invega, or both) it addressed. • Individual #439 was seen in the psychiatric clinic and the psychiatrist noted that he was not sleeping well. In addition he had been increasingly agitated and had become self abusive or aggressive to others. In different parts of documents he was variably identified as having a mood disorder (either unspecified or due to an unnamed medical condition), an impulse disorder, or dementia. The consulting psychiatrist cited the diagnosis of mood disorder secondary to a general medical condition. The consulting psychiatrist noted the recommendation of a colleague to discontinue valproic acid and concurred with that recommendation. There was no mention of a new medication. Ann authorization form for Zyprexa was submitted to the Facility director. It cited the diagnosis of Impulse control disorder that "*resulted in aggression toward self, inappropriate behavior, and refusal behavior.*" The form cited the common and standard language for treatment benefits and listed common side effects. The medication plan was submitted to the HRC. It explained that Zyprexa (an atypical antipsychotic) was to take the place of Depakote (the anticonvulsant mood stabilizer mentioned in the clinic as a medication to be discontinued). The justification was "*to eliminate the individual's irregular sleep pattern, his aggression and his combative behavior. "*	

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		Behavioral treatment monitoring was in place for aggression to self, and refusal, amongst other things. Although the psychiatrist's diagnosis was for a mood disorder, there was no monitoring for mood, or any indication of a plan to add such monitoring. The PBSP contained the standard language that *the PST would at least annually consider the gradual reduction of psychotropic medication unless the clinical evidence justifies that this is contraindicated."* • The record for Individual #439 lacked consistency regarding the working diagnosis, even among related documents (psychiatry clinic and consent). It did not contain any of the elements for a treatment plan required by J13. • Individual #199 was diagnosed with bipolar disorder, type I, most recent episode depressed. The consulting psychiatrist noted that "according to staff, she remained in a depressed state. She has been quiet and withdrawn and does not interact spontaneously with others. Earlier in the week, there was an episode described by staff that suggested some catatonic posturing." On mental status exam, psychomotor activity was significantly reduced. The consultant recommended starting the antidepressant Wellbutrin XL, recommended discontinuing Inderal since it is associated with depression in some patients, and discussed the possibility of using ECT to alleviate symptoms of depression. Consent was obtained for Wellbutrin. It correctly stated the diagnosis but there was no subsequent mention of depression. The disorder was described as one that "*results in aggression to others aggression to the environment, verbal aggression, non compliance, and work/programming refusal*." . The HRC review of added medication cited the justification as "increased rates of aggressive behavior agitation and restraint." The risk/risk analysis for the proposed medication stated "*the PBS includes procedures that post a minimal risk to (the individual). The risk of implementing this PBS include possible injury to (the individual) staff and others from PMAP protective skills; or when these skills are done wrong or done too late when aggression does occur. The PBS also includes prompting interventions in order to divert behaviors early in the behavioral change of inappropriate behaviors however under certain conditions it could bring about a full-blown incident due to an increase in agitation."* Behavioral data was collected for the target behaviors noted in the consent form, but no data was collected for symptoms of depression. The PBSP contained the standard medication reduction plan for monthly review and consideration of medication reduction at least annually. • The shortcoming of this plan included the marked discrepancy between the psychiatrist's intent to treat depression, and the subsequent documents which describe aggression. The risk vs. risk language in the consent for the medication did not address the risks of medication. The consent form relied on standard language which was too general, and the plans did not contain the details outlined in provision J13.	

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		• Individual #193 was diagnosed with bipolar disorder type II, attention deficit hyperactivity disorder, post traumatic stress and major depression. Behavioral tracking was present for various measures of aggression, and for leaving without notifying staff. The psychiatrist noted that staff reported that she tends to be impulsive and talkative. On mental status exam she was restless and fidgety, and her mood was anxious. The psychiatrist recommended the use of Intuiv. The individual's diagnoses were listed in the consent form and were linked to "aggression to others, aggression to self, aggression to environment, and leaving without notifying staff." The justification offered to the HRC was that the individual "has been exhibiting increased signs of agitation, rates of leaving without informing staff, screaming, urinating and verbal aggression." The risk vs. risk analysis for the medication listed risks that are associated with her "behaviors" but did not address any risks associated with medication treatment, such as side effects. • The program lacked clarity as to what the psychiatrist intended to achieve with the use of the medication or how it would be assessed. The language – and the typical use of Intuiv – hinted that it was to treat the symptoms of ADHD he mentions, but if so, these were not identified in the consent or HRC documents. There was no treatment monitoring for the psychiatric symptoms mentioned by the consultant such as anxiety and restlessness and the requirements for treatment specifications and monitoring outlined in provision J13 were unaddressed. The language contained in the consent, regarding treatment expectations was standard language used in all programs and was therefore not useful. • Individual #429 was diagnosed with generalized anxiety. Behaviors tracked for the clinic included aggression to self, in attempting to unbuckle the seatbelt, and unbuckling the seatbelt, injuries to self and others, restraint, hours of sleep, and meal refusals. The consulting psychiatrist mentioned that Klonopin had been discontinued two days earlier because the patient became lethargic but that on the day of clinic he was informed that the patient was again getting agitated. The psychiatrist recommended restarting the Klonopin both to prevent discontinuation syndrome and to treat restlessness and agitation. The consent gave a diagnosis of impulse control disorder NOS, not the anxiety disorder named by the psychiatrist. The identified purpose was self injury, and the expected results from the treatment were the language common to other programs. Medication side effects were included. Risk vs. Risk information was not included. The HRC review named both Klonopin, mentioned above. It also named a second medication, Zyprexa, which was not mentioned in the psychiatrist's note and for which the monitoring team was not provided a consent form. The justification was "to help reduce self injurious behaviors." Risk information stated "a *possible risk*	

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		of implementing the medication can be the various side effects associated with it." The plan to remove the restriction/intrusive component (i.e. the medication) was that the medication would be "monitored" by the psychiatrists. The PBSP for individual #429 cites a plan for medication reduction "whenever problem behaviors decrease to o episodes per month for six month. • Problems associated with this plan included inconsistency about diagnosis, lack of monitoring for symptoms of the disorder cited by the psychiatrist, the inclusion in the HRC review of a medication not mentioned by the psychiatrist and for which a consent was not provided to the monitors, reliance on standard language regarding expected results of the treatment, and absence of the specific parameters for treatment monitoring that are required by provision J13. • For individual #213 staff noted significant obsessive compulsive behaviors. These included *washing his hands repeatedly wanting to go to the bathroom to watch the water run, tapping the back of his right calf repeatedly and smelling his hands."* Behavioral tracking that was in place and presented to the clinic was for self injurious behaviors, hours of sleep, injury to self and others and restraint. The psychiatrist mentioned that there were no reports of mania or psychosis. The individual commented that the individual met criteria for obsessive compulsive disorder and recommended the use of Sertraline to target OCD symptoms. The consent presented that the individual was diagnosed with obsessive compulsive disorder that "*results in inappropriate behaviors," followed* by the standard language regarding expectations for medication treatment. Medication side effects were mentioned. During HRC review the symptoms mentioned by the psychiatrist were presented, along with many other symptoms such as details of his self injury and protective restraints. A plan for monitoring treatment with Zoloft for the repetitive behaviors was identified as "he will be follow up (sic) with direct observations to assess if the behaviors are reduced by the introduction of the Zoloft." Risks vs. risk analysis stated "the *prescribed medication is designed to reduce or eliminate OCD behaviors.*" • This program was much better than others in that it identified the particular symptoms that were relevant to the proposed diagnosis, and specific monitoring was offered. Nonetheless, this program too had many shortcomings. The consent described the symptoms to be treated only as "inappropriate behaviors" and it relied on standard language for the expected results of medication treatment. Also, many of the specific requirements of J13 were not met (expected time line for response, by whom when and how the monitoring will occur). The Risk vs. Risk section contained only a statement about the purpose of the medicine and identified no risks. • Individual #174 was diagnosed with bipolar disorder. Behavioral tracking included measures for aggression non compliance and delusional statements.	

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		She was reported to display aggression and mood instability. Treatment was in place with Invega and Depakote. Mental status demonstrated an overall increase in psychomotor activity, and the psychiatrist recommended the addition of Trileptal. The target behaviors listed for behavioral tracking were identified as the "results" of the disorder and the standard language was used to describe expected results of treatment. Side effects were listed. HRC review provided a justification as "*rates of aggression and restraints have increased."* Risk vs. risk analysis was included, but mentioned only the risks related to the "behaviors," and did not does not mention any risks related to the medication. • This plan lacked the needed details for the medication plan required by J13. The relevant symptoms for treatment were not identified, there was no timeline for effects, the objective psychiatric symptoms were not mentioned, the criteria for determining treatment efficacy were absent, and there was no mention of how the treatment efficacy would be assessed. The only psychiatric symptom tracked was delusional statements, although in his general discussion the psychiatrist focused on mood instability, and the degree of psychomotor activity. No tracking of these was in place or was proposed. Risks of medication were not mentioned in the HRC presentation. • Individual #152 was diagnosed with schizoaffective disorder and psychiatrist noted in the note for the psychiatric clinic that the individual was treated with Trileptal. Medication tracking noted that the target symptoms for Trileptal were uncontrolled hostility or excitement, anxiety, depression and irritability. The psychiatrist cited low serum sodium and proposed replacing Trileptal with Depakote, another mood stabilizing anticonvulsant. Behavioral tracking reported included aggression, self injury and food stealing. There was no tracking for the psychiatric symptoms listed above as the target behaviors/symptoms for Trileptal treatment. The consent for Depakote properly identified uncontrolled hostility, depressed mood psychomotor agitation and irritability as the relevant symptoms. • This program was better than others, since it contained a list of appropriate targets for treatment. However, there was no tracking in place for these symptoms, nor was a plan to do so proposed. Beyond the identification of the symptoms to be treated, none of the J13 requirements for medication plans were addressed. • Individual #647 was diagnosed with schizoaffective disorder. He was presented to the psychiatry clinic for complaints which included decreased sleep and nocturnal urination. Imipramine to control bedwetting and to promote sleep was recommended and consent for use of that medication was obtained. In the first part of the presentation the expected results of the treatment with imipramine were identified as "elimination of pica, handsucking, rectal digging/smearing, food stealing and aggression and replacement with socially acceptable and adaptive	

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		behaviors, improved learning of new skills, increased participation in scheduled treatment programs and leisure activities and access to less restrictive setting." A table of psychotropic medications followed, and imipramine was described as targeting "restlessness, agitation and enuresis." Side effect information was included. The HRC review correctly identified insomnia and enuresis as the reasons the medication was proposed. The risk analysis states that the risk associated with insomnia outweigh the risk associated with the medication but failed to state that the risk of medication was the side effects mentioned in the consent form. No plan was offered to monitor treatment effects and no tracking was in place for the target symptoms that were identified. • Individual #740 was diagnosed with schizoaffective disorder. Documentation from the psychiatric clinic was not provided to the monitors, but a note from a later clinic clarified that the psychiatrist had prescribed clozapine due to an increase in the patient's aggressive behavior and to help manage mood stability. Consent for clozapine listed symptoms that included various measures of aggression, unauthorized departure, and noncompliance, and expectations for treatment followed the language common to all plans. HRC review listed aggression and mood stability as the reason for the medication, and the justification listed various symptoms of disruptive and noncompliant symptoms. Problems particular to this program included the lack of any measures for the mood stability cited by the psychiatrist (which could be a basis for the diagnosis of schizoaffective disorder), and the lack of a medication treatment plan that contained the required elements for such a plan that is identified in the language of the provision. As illustrated by the examples listed above, the Facility did not provide medication plans for the psychotropic medications that were required by provision J13. Instead, medications were used in a nonspecific manner, to address "problem behaviors" identified in the psychologists overall behavioral program. During the tour the monitoring team was informed that several workgroups were in place and were working to develop procedure to address requirements of the SA, including provision J13. Progress in these efforts will be reviewed during the next tour.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case	Materials reviewed for this provision were the records of 10 individuals who were recently prescribed psychotropic medications. These individuals were #41, #152, #174, #193, #199, #213, #429, #439, #647, and #740. Informed consent forms were provided for all individuals. The consent forms were reviewed for required elements of consent, as follows:	N

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	of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Appropriate authorization by the legally authorized representative (LAR): All ten forms were signed by the legal guardian or Facility director. Psychiatric Diagnosis: All ten consent forms listed a psychiatric diagnosis that was reported to be connected to the proposed medication. In two of the forms, the diagnosis listed on the consent form was different than the diagnosis that was listed by the psychiatrist who recommended that the medication be prescribed. In the case of Individual #439 the psychiatrist listed the diagnosis of mood disorder secondary to a general medical condition, but the consent form listed the diagnosis of impulse control disorder. In the case of Individual #429 the psychiatrist listed the diagnosis of generalized anxiety, but the consent form listed the diagnosis of impulse control disorder. Purpose of the medication and proposed benefits of treatment: In one case, that of Individual #152, psychiatric symptoms that were relevant to the psychiatric diagnosis was listed as the reason that the psychotropic medication was needed. In all other cases, the consent form named targets of the psychologists' behavioral interventions as the reason the medication was proposed. In all cases, the benefits of the medication were stated to be reductions in the psychologist's behavioral target. These behavioral targets could not be linked to symptoms of the psychiatric diagnoses. In all cases, statements about putative benefits were followed by an insertion of standard language that stated problem behaviors would be replaced with "socially acceptable and adaptive behaviors, improving learning of new skills, increased participation in scheduled treatment programs and leisure activities and access to less restrictive setting." This statement was perhaps relevant to the overall treatment program, but not to the medication treatment that was proposed. The following table was constructed from information contained in each individual's medication consent form. It demonstrated the proposed linkages between the psychiatric diagnoses, behavioral "results" of the diagnosis, and possible benefits of the proposed medication treatment. The first linkage that was needed was the linkage between the diagnosis and behavioral symptoms/"results" of the diagnosis. In only one case (#152) was that linkage present. In many other individuals, there was simply no connection between the cited diagnosis and the cited symptoms. For example, individual #647 is identified as having schizoaffective disorder that, per the consent form, resulted in pica, hand sucking, rectal digging/smearing, food stealing and aggression. But none of these symptoms are part of the diagnosis of schizoaffective disorder. The second linkage that was needed was between the proposed medication and the cited expected benefits from the medication. In all cases, the proposed benefits of the treatments were simply restatements of the overarching goals of psychological treatment, and were not connection	

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to known effects of the proposed medication.

Individual #	Proposed medication	Diagnosis	Result of diagnosis, per consent form:	Benefits
439	Zyprexa	Impulse control disorder	Aggression toward self, inappropriate behavior, refusal behavior	Elimination or reduction in rates of ATS inappropriate behavior refusal behavior behavior, and replacement with (standard language cited above)
041	Abilify	OCD and autism	Inappropriate behaviors	Elimination or reduction in rates of such behaviors and replacement with (standard language cited above)
193	Intuiv	Bipolar disorder	Aggression to others, aggression to self, aggression to the environment , and leaving without notifying staff	Elimination or reduction in rates of aggression to others, aggression self aggression to the environment and leaving without notifying staff and replacement with (standard language cited above)
647		Schizoaffective disorder	Pica, hand sucking, rectal digging/smearing, food stealing and aggression	Elimination or reduction in rates of pica, handsucking, rectal digging/smearing, food stealing and aggression and replacement with (standard language

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						cited above)	
		174	Trileptal	Bipolar Type 1	Aggression to self, aggression to others, aggression to environment, verbal aggression, non-compliance, and delusional statements.	Elimination or reduction in rates of aggression to self, aggression to others, aggression to environment , verbal aggression, non- compliance, and delusional statements, and replacement with (standard language cited above)	
		213	Zoloft	Obsessive compulsive disorder	Ongoing inappropriate behaviors	The elimination or reduction in rates of such and replacement with (standard language cited above	
		740	Clozapine	Schizoaffective Disorder	Aggression (to) self, aggression to others, verbal aggression, aggression to environment non-compliance leaving or attempting to leave designated/assigned area and unauthorized departure	(Reductions in) aggression (to) self aggression to others verbal aggression, aggression to environment non-compliance leaving or attempting to leave designated/assigned area and unauthorized departure behaviors and replacement with (standard language cited above	
		152	Depakote	Schizoaffective disorder	Uncontrolled hostility or excitement,	Elimination in rates of self injurious behavior aggression	

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<tr><td></td><td></td><td></td><td>depressed mood, psychomotor agitation and irritability</td><td>to others and aggression toward the environment behaviors and replacement with (standard language cited above</td></tr>
<tr><td>429</td><td>Klonopin</td><td>Impulse disorder</td><td>Self injury</td><td>Elimination in rates of self injury behaviors and replacement with (standard language cited above)</td></tr>
<tr><td>199</td><td>Wellbutrin</td><td>Bipolar disorder most recent episode depressed</td><td>Aggression to others, aggression to environment, verbal aggression, non-compliance and work/programming refusal</td><td>Elimination in rates of aggression to others, aggression to environment, verbal aggression, non-compliance and work/programming refusal behaviors and replacement with (standard language cited above</td></tr>
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<u>Information on side effects:</u> Side effect information was provided in all cases.

<u>HRC review:</u> HRC review was present in all cases. Some of the information on the HRC review was relevant to provision J13 and J10, and that information is reviewed under those provisions.

Overall, informed consent documents were deficient for the same reason cited elsewhere in this review: Medications were prescribed as ancillary to general behavioral treatments, and were not based on symptoms of psychiatric diagnoses. As a result, the LAR could not be provided with information needed to make an informed decision about the proposed use of the medication.
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<tr><td>J15</td><td>Commencing within six months of the Effective Date hereof and with</td><td>The baseline report of the monitoring team noted that there was written communication between the consulting neurologist and consulting psychiatrist. This was also the case</td><td>N</td></tr>
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	full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	during the six months since the baseline tour. With the recent hiring of staff psychiatrists it should be possible for those psychiatrists to communicate more directly with the neurologist, or to attend relevant on–site neurology clinics appointments for those individuals under their care who are prescribed with anticonvulsant medications for both seizure control and a diagnosed psychiatric disorder.	

Recommendations:

1. Future psychiatric assessments should put increased emphasis on identification of behaviorally observable symptoms of proposed psychiatric disorders, present and past. Such symptoms should be the basis of proposed medication treatments.
2. The Facility should review/develop procedures for psychology and psychiatry (and other disciplines as appropriate) to undertake combined assessment and case formulations, so as to identify the best array of behavioral healthcare treatments offered to the individual.
3. The Facility should review and develop procedures for medical providers on the PST (nurse, physician, psychiatrist and when appropriate, neurologist) to participate more fully in evaluating medical risks and possible benefits of proposed psychotropic medication treatments.
4. The Facility must implement a review system to monitor psychiatric polypharmacy on a monthly basis. The Facility should consider including a peer review component in the polypharmacy review system, which would evaluate whether polypharmacy regimens are appropriate, and if so to document on what basis the determination is made. The Facility should consider the inclusion in the polypharmacy reports of periodic updates on plans/efforts to simplify drug regimens when peer review has supported the need to do so.
5. The treating psychiatrist must review/sign QDRRs and DISCUS evaluations.
6. The Facility should develop a list of individuals who have been found on the basis of DISCUS screenings to have tardive dyskinesia; the Facility should make sure that such diagnoses are listed in the individual's master list of clinical diagnoses; and the Facility should develop a system to monitor periodically the status of individuals diagnosed with tardive dyskinesia.
7. Criteria for evaluation of success of DSPs and MSPs should be developed. The results should be available to the PSTs, so that improvements in on-going individual plans can be made. Facility wide reports should be generated which tabulate DSP's assessed effectiveness, to facilitate quality assurance and quality improvement efforts. The Facility should consider expanding efforts to monitor not only DSPs but also MSPs as well, if this is not already being done.
8. The Facility should consider whether existing processes can accommodate the requirements for the medication plans described in provision J13, or whether a document should be generated when plans are proposed that would address the many requirements of the provision. If the Facility concludes that the details are best laid out in one document, the Facility should further consider whether the contents should then be incorporated into an existing document (such as the PBSP) or whether the contents should remain as a free standing document, for ongoing reference.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Documents that were reviewed included the annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, and behavioral and functional assessments. All documents were reviewed in the context of the POI and Supplemental POI and included the following individuals: #8, #16, #24, #25, #36, #44, #52, #60, #115, #149, #199, #212, #267, #271, #282, #302, #315, #318, #328, #340, #344, #346, #353, #363, #399, #405, #415, #424, #426, #437, #448, #452, #455, #465, #493, #501, #525, #535, #547, #548, #551, #569, #583, #597, #612, #613, #630, #634, #643, #678, #740, #756, #758, #772, #779 and #794 2. Subsets of the individuals reviewed included: • Counseling/psychotherapy documentation for individuals #424, #448, #493, #547, #583, #597, #613, #740 and #779 • Best work samples provided by psychology staff for individuals #8, #16, #25, #44, #52, #115, #282, #302, #318, #344, #363, #399, #415, #437, #501, #535 and #756 **People Interviewed:** 1. William Eckenroth, PhD – Director of Behavioral Services 2. Don Williams, PhD, BCBA – Contractual psychologist 3. Deborah Grossett, PhD, BCBA – Contractual Psychologist 4. Cynthia Fannin – Director of Education and Training 5. Carol Agu – QMRP Coordinator 6. Heather Blackwell – Director of Vocational Services 7. Jim North – Rights Protection Officer 8. Donald Pavliska – Competency Training and Development **Meetings Attended/Observations:** 1. Human Rights Committee meeting (10/28/2010) 2. Psychology Peer Review Committee meeting (10/25/2010) 3. Neches Morning Meeting (10/26/2010) 4. Observed training, active treatment, staff interaction and meals at the following residences: Leon, Neches, Sabine, San Antonio, San Jacinto
	Facility Self-Assessment: The Facility indicated that no full provisions of the SA were in substantial compliance. Provision K2, pertaining to the qualifications of the Director of Behavioral Services, was determined by the Monitoring Team to be in substantial compliance..
	Summary of Monitor's Assessment:

	Behavioral Services Department at RSSLC was noted to have made limited progress during the time since the baseline visit. The number of Behavioral Services staff enrolled in courses relating to BCBA credentialing increased substantially. This was positive, although a minimum of 18 to 24 months will be required before these staff would be prepared to sit for the board certification examination. Until that time, the Facility had only one staff member who was board certified, with three additional staff approved to sit for the examination in the coming several months. This lack of demonstrably competent staff will substantially limit the ability of the Facility to address several areas of the Settlement Agreement. The Facility also reported that the Behavioral Services department had established several workgroups to develop recommendations regarding changes needed to achieve compliance with the Settlement Agreement. Such workgroups could be very helpful to the process, but almost a year had passed in the Settlement Agreement process before the groups were established. In several other areas, the Facility had made no notable progress. This was of particular concern in relation to the ability of the Facility to provide safety, security and prompt access to treatment for identified needs. For the majority of individuals living at RSSLC, there was no assessment of behavioral, intellectual, or adaptive functioning that conformed to accepted practices. The process for reviewing behavior assessment and intervention plans lacked formality and failed to ensure that assessments and interventions conformed to accepted practices. The review process for ensuring safe and effective intervention often required several weeks, delaying the implementation of treatment plans and potentially subjecting individuals to unnecessary risk. In one circumstance an individual with known serious health conditions was repeatedly subjected to restraint that could have resulted in severe personal injury or death. Data collection practices were noted to lack specificity and were not individualized. The monitoring of behavioral interventions was substantially hindered by data collection and graphing practices. Based upon the observations and record reviews conducted during this site visit, there was little indication that RSSLC typically acted in a prompt or prudent manner when assessing the behavioral needs of individuals and ensuring safe and essential interventions. **For Provision K.1:** The provision was determined not to be in compliance. The Facility had made progress in increasing participation in classes for BCBA preparation, but was not able to demonstrate that PBSPs had been developed by personnel competent in applied behavior analysis. **For Provision K.2:** This Provision was determined to be in compliance. The Director of Behavioral Services possessed all required qualifications. He also was participating in classes and supervision, and anticipated sitting for the board certification exam within the next several months. **For Provision K.3:** This Provision was determined not to be in compliance. The Facility was unable to demonstrate that peer

	review practices were objective, reliable and capable of ensuring safe and effective interventions. **For Provision K.4:** This Provision was determined not to be in compliance. Numerous limitations in data collection procedures were documented during the site visit. In addition, many reviewed records reflected an inability of the facility to effectively monitor responses to interventions and conduct the necessary modifications to assessment and intervention plans. **For Provision K.5:** This Provision was determined not to be in compliance. Documentation at the Facility reflected that assessments were rarely conducted as frequently as necessary or in a manner that produced meaningful results. No records reviewed included adaptive or intellectual assessments conducted within the stipulated time frames. Functional assessments often lacked all essential components and typically did not produce specific hypotheses regarding function. **For Provision K.6:** This Provision was determined not to be in compliance. Based upon the documentation in the record, assessments were not demonstrated to be current, accurate, or complete. **For Provision K.7:** This Provision was determined not to be in compliance. While all individuals recently admitted to the Facility had a Psychological Assessment, there were no indications that new intellectual or adaptive assessments were conducted once a person began to live at the Facility. **For Provision K.8:** This Provision was determined not to be in compliance. At the time of the site visit, non-PBSP services lacked formality and did not reflect an empirical approach to treatment. **For Provision K.9:** This Provision was determined not to be in compliance. The necessary consent and approval forms were available for most individuals, but often reflected substantial delays. In at least one circumstance, the efforts of the Facility failed to prevent repeated exposure to dangerous and life-threatening restraint. **For Provision K.10:** This Provision was determined not to be in compliance. The Facility had not implemented a routine procedure for assessing the quality of behavior data. In addition, graphs often presented data in a manner that allowed data trends to be misinterpreted. **For Provision K.11:** This Provision was determined not to be in compliance. At the time of the site visit, the Facility did not routinely assess the implementation of PBSPs.

	For Provision K.12: This Provision was determined not to be in compliance. The Facility did not employ a competency-based approach to staff training. In the majority of cases, training on PBSPs was typically conducted only when the PBSP was first implemented. In addition, the Facility had not developed or implemented a system to ensure that pulled or relief staff were provided with training on PBSPs. **For Provision K.13:** This Provision was determined not to be in compliance. The Facility fell far short of the required ratio of one BCBA for every 30 individuals.

#	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.	Since the baseline visit to RSSLC, the Facility had made progress toward ensuring that all staff were demonstrably competent in applied behavior analysis. Evidence of this progress included the following actions. • The number of BCBAs on staff had increased by one, a recently hired psychologist, for a total of one staff with board certification. • Eleven Behavioral Services staff (9 Psychologists, 1 Psychological Assistant and 1 Psychiatric Assistant) had enrolled in BCBA preparatory classes at the University of North Texas. • Three Behavioral Services staff had been approved to sit for the BCBA examination. The degree of progress noted in promoting enrollment in BCBA training was admirable. Substantial time will be required before these staff can complete training and achieve board certification, thereby setting a minimum of 18 to 24 months before compliance with the Settlement Agreement can be achieved for this Provision. Nevertheless, the increase in enrollment is welcome and noteworthy. Although progress was noted in initiating enrollment in BCBA training, the lack of Behavioral Services staff with the BCBA credential resulted in no PBSPs having been developed by staff demonstrably competent in applied behavior analysis. At the time of the most recent site visit, numerous PBSPs at RSSLC did not meet standards of practice in applied behavior analysis and were not based upon acceptable assessments. Sections in this report corresponding to Provisions K4, K5, K6, K7 and K9 of the Settlement Agreement document more fully the limitations noted in behavior assessment and intervention. In relation to Provision K1, it was evident that no PBSPs could be supported as having promoted the growth, development, and independence; minimized regression and loss of skills; and ensured reasonable safety, security, and freedom from undue use	N

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		of restraint.	
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.	At the time of the site visit, RSSLC employed a full-time director of Behavioral Services; William Eckenroth, PhD. Dr. Eckenroth had extensive experience in the field of intellectual and developmental disabilities. Based upon his experience and and qualifications, Dr. Eckenroth's role as Director of Behavioral Services was considered by the Monitoring Team to reflect substantial compliance with the Settlement Agreement.	SC
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	The role of peer review committees has been briefly defined in behavior analysis literature as follows. *"In cases in which withholding or implementing treatment involves potential risk, Peer Review Committees and Human Rights Committees play distinct roles in protecting client welfare. Peer Review Committees, comprised of experts in behavior analysis, impose professional standards to determine the clinical propriety of treatment programs." (The Right to Effective Behavioral Treatment. Van Houten, R. et.al. 1988. Journal of Applied Behavior Analysis, 21, 381-384.* In order to meet these goals, an organization or Facility must ensure that the necessary resources are available, policies and procedures are implemented, and demonstrably competent staff participate. In addition, steps must be taken to ensure that the implementation of peer review does result in interventions that adhere to acceptable practices. During the baseline visit in April, 2010, Peer Review Committee meetings lacked structure and a true peer review process. Discussion consisted primarily of a clerical review of documents. Committee members evidenced a general lack of familiarity with basic applied behavior analysis. At that time, no committee members were board certified behavior analysts. Although some changes have been implemented since the baseline visit, there was little evidence to support a substantial improvement in the peer review process at RSSLC. At the time of the site visit, RSSLC lacked the demonstrably competent Behavioral Services staff necessary to accomplish internal peer review. Documentation reflected that peer review meetings had been conducted, but, until a few weeks prior to the site visit, without qualified staff. In September 2010, RSSLC implemented a joint internal and external peer review process that included two BCBAs with extensive experience in working with people with	N

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		intellectual and developmental disabilities. Observations of a Peer Review Committee meeting conducted during the site visit, as well as a review of documents from that meeting, noted the following. • For Individual #25: o The reviewer noted a lack of functional assessment or data and recommended additional assessments and data review. o The reviewer indicated that the replacement behavior should be changed and that a description of data collection procedures was needed, Inquiry was also made regarding data not included in the submitted plan, such as the frequency of self-injurious behavior, the number of injuries inflicted, and the frequency and duration of restraint applications. o The reviewer stated that a "nice job" had been done with the plan. The Committee approved the plan with revisions. Revisions were not completed by the end of the site visit. Per report of the Director of Behavioral Services, supervising psychology staff were expected to ensure that revisions were made but there was no formal oversight or reporting process to ensure this occurred and that revisions were adequate. • For Individual #199: o The reviewer noted a lack of functional assessment or data and recommended additional assessments and data review. o The reviewer indicated that the replacement behavior should be changed, that the existing plan upon which the submitted plan was based had resulted in an increase in the target behaviors and that a description of data collection procedures was needed. Inquiry was also made regarding data not included in the submitted plan, such as the frequency and duration of restraint applications. o The Committee deferred approval of the plan and required resubmission with revisions; it was unclear how the plan differed from plans with similar issues that had been approved with revisions and required no additional Committee review. • For Individual #448: o The reviewer praised the identified functions although commenting upon the lack of clarity in the description of functional assessment procedures. o The reviewer recommended additional data review, a justification of identified functions, the completion of a preference assessment, and the elimination of "non-behavioral" intervention procedures. o The reviewer indicated the plan under review, which was a continuation of an existing plan, had not been "working well," as aggression, elopement and restraint had increased. o When the reviewer inquired about medical conditions, it was indicated that the individual had a pacemaker. The reviewer cautioned that a physician needed to	

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		indicate there were no contraindications for the use of four-point restraint. o The Committee approved the plan with revisions. Such approval does not require additional Committee review. Revisions were not completed by the end of the site visit. • For Individual #770: o The reviewer commented that a functional assessment had been completed by using the Functional Assessment Screening Tool (FAST) and the Motivation Assessment Scale (MAS). Neither of these instruments is consider to be a functional assessment, as has been stated by the developer of each instrument. o The reviewer indicated the need for additional review of data for the past 12 months, a change in the replacement behavior, a methodology revision to stop the inadvertent reinforcement of the undesired behavior, and the addition a behavioral momentum procedure; it was also indicated that the risk analysis lacked data to support claims of risk. Despite the multiple short-comings, the reviewer stated that "a nice job" had been done on the plan. o The Committee voted to approve the plan with revisions. Such approval does not require additional Committee review. Revisions had not been completed by the end of the site visit. A number of weaknesses in the peer review process were revealed by the observations and document review. The most egregious of these weaknesses was the failure to provide and consider the full medical complications experienced by Individual #448. It was correctly reported that he had a pacemaker. It was not reported, however, that he also possessed a variety of congenital heart malformations and other medical conditions that could result in death if the individual was placed under duress or experienced unnecessary physical exertion. The exertion involved in the application of restraint, according to the physician on the Settlement Agreement Monitoring Team, constituted excessive physical exertion. The behavior intervention for Individual #448 was indicated to lack clarity and thoroughness in assessment, included non-behavioral intervention methods, was ineffective in reducing aggression and elopement, and included the use of mechanical restraint. When the submitted plan was approved, the Committee and the Facility failed to ensure that adequate treatment procedures were in place and failed to ensure that the individual was protected from unnecessary risk of personal harm. The information regarding the four submissions to the RSSLC Peer Review Committee also indicated an ongoing failure to require adequate functional assessment. The Committee equated screening tools with functional assessment and approved plans with revision that were noted to lack functional assessment and data. A behavioral	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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intervention that was not based upon an adequate functional assessment lacks even the minimal basis upon which revisions can be made. Without a functional assessment and objective, measurable data, there is insufficient understanding of the behavior to develop or revise an intervention. Having approved the noted plans even though the peer review identified the need for further functional and preference assessment, the Peer Review Committee established a standard of less than adequate adherence to the basic practice of applied behavior analysis.

The following reflects a sound approach to the assessment of behavior.

A. <u>Step 1: Observation</u>
<table>
<tr><th>Scientific Method</th><th>Non-Scientific</th></tr>
<tr><td>Independent, objective observation results in a collection of facts regarding an event, situation, etc.</td><td>Circumstances or people dictate how to perceive and interpret an event or situation</td></tr>
<tr><td>Crystal rarely ties her shoes</td><td>Crystal refuses to tie her shoes</td></tr>
<tr><td>Students in Enrique's class often talk and walk about</td><td>Students in Enrique's class are rebellious and unmanageable</td></tr>
</table>
1. When it is first suggested that a training program might be needed, it is important to conduct direct observation.
a) Multiple settings
b) Multiple times
c) Tools such as
(1) ABC observation forms
(2) Narrative recording
(3) Scatterplots
(4) Frequency data forms
2. IMPORTANT!
a) Observational data reveal correlational relationships not causal relationships
b) These data are not useful in developing or implementing interventions without completing the rest of the scientific method process

B. <u>Step 2: Identify a Question</u>
1. Identify a question regarding the observational data
</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		a) Why does Crystal tie her shoes only 19% of the time before class? b) Why does each of Enrique's students walk about the classroom an average of 87 minutes per day? 2. Does not focus upon intervention 3. Emphasizes understanding the person in the context of their environment C. <u>Step 3: Formulate an Hypothesis</u> 1. Requires additional observation and assessment 2. Usually involves greater control and technical sophistication 3. Essential tools include a) Functional assessment b) Functional analysis c) Reinforcer and preference assessment 4. An hypothesis will include the identification of a) Strengths b) Needs c) Antecedents d) Consequences e) Display parameters, such a frequency and duration f) Reinforcers g) Functions or purposes 5. An hypothesis will not identify causal relationships 6. An hypothesis will a) Suggest potential causes b) Provide a foundation for conducting an investigation of causality c) Include a conceptualization of an intervention 7. Example of an hypothesis. a) When Crystal is allowed less than 15 minutes to dress herself AND b) staff frequently and forcefully prompt her to finish dressing without including clear verbal instructions on how to tie her shoes THEN c) Crystal will put on her shoes without tying the laces and walk to the classroom WHERE d) The frequency of verbal prompts to dress drops by 85% 8. The predictive part of the hypothesis a) IF Crystal is allowed MORE than 15 minutes to dress herself b) IF staff prompt her with LESS frequency and force c) IF staff DO provide clear verbal instructions on how to tie her shoes	

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		THEN d) The frequency of Crystal tying her shoes will increase by at least 50% D. <u>Step 4: Test Your Hypothesis</u> • A specific and detailed process to test if your hypothesis is correct 1. Change in the variables based on the hypothesis: a) Independent Variable(s) (What you change) (1) Time allowed to dress (2) Frequency and intensity of prompts (3) Instructions for tying shoes b) Dependent Variable (What you expect to change) (1) How frequently Crystal ties her shoes before class 2. This is also an intervention a) If your experiment shows that your changes to the independent variables (Time to dress, prompts, etc.) b) Resulted in an increase in the dependent variable (Frequency of tying shoes) c) You have implemented a successful intervention E. <u>Step 5: Analysis</u> 1. The only way to effectively determine if your hypothesis and prediction were correct is through the use of a precise system for collecting and interpreting data 2. Data interpretation must show a clear relationship between your independent and dependent variables 3. Data must have a) Validity (1) Whether you data measure what you intended to measure b) Reliability (1) Whether your data consistently measure your variables across time It was also noted from the Peer Review Committee materials that multiple recommendations for the inclusion of other intervention strategies were offered during the Committee meeting. All aspects of a behavior intervention are to be based upon the functional assessment. When recommendations were offered, and plans approved based upon the assumed inclusion of recommendations in the plan revisions, the Peer Review Committee failed to abide by the basic practice guidelines of applied behavior analysis. In addition, this failure conveyed to Behavioral Services staff that the basic practice guidelines for applied behavior analysis would not be required in the development of behavior interventions at RSSLC. The peer review process also lacked objective and measurable guidelines for	

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		determining whether a submitted plan was adequate. As noted above, a great deal of similarity was noted between plans that were approved with revision and those that were deferred approval. The process of peer review must be both accurate and consistent. A final issue involved the practice of approving a behavior intervention with the assumption that the recommended revisions would be implemented adequately. As noted in Provision K1, RSSLC lacked demonstrably competent Behavioral Services staff at the time of the site visit. It was unclear why the Peer Review Committee did not require additional review for all revised plans given the skills the staff were noted to lack.	
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.	During the baseline visit in April of 2010, it was noted that data collection for PBSPs at RSSLC was inadequate to the task of measuring behavior and determining the need for or benefit from behavioral or psychopharmacological interventions. In 24 out of 24 records reviewed, data collection consisted of narrative documentation of circumstances surrounding the display of an undesired behavior. Since the baseline visit, RSSLC had implemented minimal changes to the data collection process. Records and reports from Facility staff indicated that it was not until September, 2010, that a workgroup had been assembled with the task of identifying alternatives to the existing data collection practices. Observations and record reviews reflected the lack of change in data collection practices. • Efforts had not been made to establish a selection process for data collection methods that might be useful for a range of behaviors. The Facility continued to use a single data collection method for targeted behaviors. In 36 of 36 records reviewed (100%), data collection consisted of "DRA Data Sheets" that allowed for the recording of low frequency displays of behavior combined with narrative statements concerning the display context. These data sheets might be appropriate in some cases but not all. • In 36 of 36 records reviewed (100%), there was no indication of attempts to collect interobserver agreement on treatment data to determine that definitions were adequate and ensure that the data could be valid. The data system also needs to be more sensitive to each individual's needs. That is, in addition to being designed to make it possible for DCPs to collect accurately and efficiently, the data system needs to provide information that allows assessment of both behaviors that occur at low rates (e.g., intense but infrequent aggressive behavior), as well as behaviors that occur at very high rates (e.g., stereotypic behavior, undesirable verbal behavior). Depending on the target behavior and its frequency, the Facility should use a range of measures, such as frequency, time sampling, and duration measures. It is	N

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		recommended that the facility expand its data collection system to allow it to assess the occurrence of all target and replacement behaviors accurately. In addition to limitations noted in data collection, the practices used in the compiling and graphing of treatment data at RSSLC continued to present substantial weaknesses. These weaknesses or limitations included the following: • In 36 of 36 records reviewed (100%), monthly data graphs presented data as the daily mean displays of behavior per week. Reporting daily mean frequency is inadequate as it fails to differentiate between behaviors that are presented in bursts and those that are displayed at a consistent low frequency, and does not provide a meaningful measure of behaviors that occur at high frequencies • In 36 of 36 records (100%), treatment objectives were stated in terms of total frequency while data were presented as daily mean frequency per week. • In 36 of 36 records (100%), progress notes and other data reports presented multiple data graphs for a single treatment plan. These data graphs typically did not share the same Y-axis scale. For example, the progress note for Individual #353 included four data graphs with four different Y-axis maximum values (.07, .30, .40 and 1.0). In order to allow comparisons of different measures on different graphs, it is essential that the Y-axis (the vertical axis on the graph) on each graph use the same scale of measurement. When the scale of measurement is different on each graph, much like having distance measured in inches on graph one and kilometers on graph two, comparisons cannot be easily made between the two graphs or data sets. • In 36 of 36 records (100%), no indications of treatment conditions were included. Without an indication of when a behavior intervention or psychotropic medication was started or changed, it is not possible to determine if that treatment produced a change in the treatment target. As a result of the issues presented above, it was not possible in the majority of cases to determine whether a PBSP or psychotropic medication was providing any benefit to the individual or even if it was causing harm. Substantial changes in data collection practices will be necessary for RSSLC to make progress toward satisfying this portion of the Settlement Agreement. One additional limitation was noted in regard to data and treatment monitoring at RSSLC. In 36 of 36 (100%) of records reviewed, progress notes did not differentiate between treatment targets. One of the key features of applied behavior analysis is the use of an empirical or scientific process to ensure that interventions produce observable and measurable changes in the targeted behavior. This requires that the target of the intervention consist of a single	

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		behavior or a group of behaviors, called a functional class, that have been proven to serve the same purpose under the same conditions. In order to determine the success of the intervention, measurements and treatment decisions must focus only upon the specific behavior or functional class. Frequently at RSSLC, data and progress notes did not focus upon the specific behavior or functional class, instead presenting a variety of behaviors without indication of function or functional relationships. Because the same interventions might have varying effects on different behaviors that are in different functional classes, grouping the target behaviors into one aggregate data point may mask the effects of the intervention.	
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.	The Behavioral Services department was asked to provide a "best work" sample from each staff member within the department. This sample of 17 records was used to assess the current status of behavior assessment and intervention at RSSLC. Documentation provided by the Facility indicated that in no area of Provision K5 was there substantial compliance with the Settlement Agreement. A review of records indicated that the Facility assessment was accurate. Intellectual and adaptive testing results play an integral role in understanding an individual. While a functional assessment may provide vital information regarding a single behavior or functional class of behaviors, , intellectual and adaptive testing provide insight into current skills of an individual and techniques likely to be effective in facilitating learning and promoting behavior change. Such testing can also facilitate the selection of skills the individual can learn. To be useful, however, it is important that the tests be relatively recent, within one year for adaptive testing and five years for intellectual testing. In addition, interpretation of the results of the tests must go beyond the reporting of scores and elaborate upon specific abilities and limitations, and how those abilities and limitations are manifested in the person's daily activities. In 17 of 17 records (100%) from in the sample, a document indicated to be the Psychological Assessment was included. In none of the 17 Psychological Assessments was there documentation to support that the information contained in the Assessment was current, accurate and relevant to the understanding of the individual's strengths and needs. • Zero of 17 (0%) Psychological Assessments contained findings from an intellectual test administered within the previous five years. • Zero of 17 (0%) Psychological Assessments included a narrative summary of how the results from intellectual assessments more than five years prior would facilitate the understanding of the individual's strengths and needs. • Zero of 17 (0%) Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological	N

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		Assessment. • Zero of 17 (0%) Psychological Assessments included a narrative summary of how the results from adaptive assessments current or otherwise would facilitate the understanding of the individual's strengths and needs. When questioned about the lack of current intellectual or adaptive assessments, the Director of Behavioral Services indicated that the department "saw no value in" such assessments and "really had no interest in" conducting intellectual and adaptive testing. The stated plan involved waiting until State Office provided direction regarding what the department would be required to do. A comprehensive Psychological Assessment must also include at least an adequate functional assessment, if not a full analogue functional analysis, if the individual presents with a behavior disturbance or indications of a mental illness. As the sample of best work provided by the Behavioral Services department was to involve an individual for whom a PBSP had been developed, it was expected that each record in the sample would include a current and acceptable functional assessment or analysis. This was not the case. • Zero of 17 (0%) of records in the sample included a formal functional assessment process that would meet accepted standards of applied behavior analysis. The assessment of behavioral function is more than the completion of a screening tool, interview or series of observations. Determining the function of a behavior is an empirical process that begins with general observation and progresses with increasing control and focus through screenings, interviews, and formal observations until a specific hypothesis regarding the function or purpose of the undesired behavior is developed. An acceptable functional assessment or functional analysis does not produce only a series of statements regarding a variety of possible functions of the undesired behavior without any further investigation to clarify which function is most likely. Rather, the product of the assessment process is a specific data-based statement regarding the most likely function of the behavior. Instead, assessment reports often contained multiple statements regarding function; these were not based upon a formal assessment process. For example, an assessment report might state that the target behavior could be due to attention seeking, escape, or internal functions. The assessments did not identify which of these potential functions was the most likely and formulate an appropriate hypothesis statement. • Zero of 17 (0%) assessments produced a specific statement or hypothesis of function. • Zero of 17 (0%) functional assessments consisted of procedures conducted a year or	

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		less prior to the initiation date of the PBSP. • Zero of 17 (0%) functional assessments described formal assessment procedures. The lack of adequate functional assessment was of particular concern in relation to individuals with a repertoire of behaviors that were dangerous to themselves and/or others. • Individual #16 presented a lengthy history of severe pica and hand-mouthing/biting, and had required restrictive procedures since admission to RSSLC. No formal assessment of function was presented in the individual's record. A statement of function relating to automatic reinforcement was included in the PBSP, but was contradicted by narrative descriptions that suggested escape as a function. • Individual #399 presented with a history of biting her hand and/or fingers with historical results of bruised tissue and broken bones. No formal assessment of the function of the behavior was included in the record. Functional assessment is an essential component of development of behavioral interventions. Especially when problematic behaviors continue over an extended time, even when formal behavior change programs have been implemented, formal functional assessment is required. When an individual is known to display dangerous behavior and no functional assessment is completed as part of the treatment development process, the most probable outcome is a continuation of the dangerous behavior. Under those circumstances, such as in the case of Individual #16 and Individual #399, the failure to conduct a formal functional assessment is indicative of a failure to provide adequate protection to an individual at risk. The assessment of mental illness is also an integral part of the Psychological Assessment. In people with intellectual and developmental disabilities, the assessment process must contribute to the diagnosis of the mental illness being experienced by the individual, as well as determine which undesired behaviors are primarily related to mental illness, which behaviors arise primarily due to learning and the environment, and which may reflect a combined origin of mental illness and the environment. To accomplish this task, assessment should consist of an objective assessment of mental illness using an instrument or process designed for people with intellectual and developmental disabilities, as well as a functional assessment. Eleven of 17 records included in the best work sample provided by the Behavioral Services department involved individuals diagnosed with at least one mental illness and prescribed at least one psychotropic medication. Observations, interviews and record reviews revealed that substantial weaknesses existed in the process of diagnosing mental illness and developing acceptable interventions. Most often, Psychological Assessments	

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		did not integrate the objective assessment of mental illness into the evaluation process or include behaviors correlated with mental illness in the functional assessment process. • Eleven of 11 (100%) Psychological Assessments included a score from an instrument designed for the assessment of mental illness in people with intellectual and developmental disabilities. These scores, however, were not fully identified (the instrument typically results in a number of scores), and no discussion was included to describe how the assessment score related to the individual's behavior or psychological status. • Zero of 11 (0%) Psychological Assessments integrated mental illness into the functional assessment process. • Zero of 11 (0%) Psychological Assessments integrated mental illness assessments into the findings of the of the assessment report.	
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.	Based upon the information presented in K5, minimal documentation in the record reflected assessment findings that were demonstrated to be current, accurate or complete.	N
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.	Records reflect that individuals newly admitted to the Facility had a psychological assessment completed within 30 days of admission. Records did not reflect that individuals admitted to the facility routinely received an intellectual or adaptive assessment at the time of admission regardless of the duration of time since the most recent assessment. Observations indicated this pattern continued throughout the time an individual lived at the Facility. There were no indications that new intellectual or adaptive assessments were conducted once a person began to live at the Facility. • Zero of 36 records (0%) included an intellectual assessment that had been administered within the past five years or an adaptive assessment that had been completed in the past year.	N
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	At the time of the site visit, 17 individuals were involved in psychological services other than PBSPs. The Facility reported that a variety of counseling strategies were utilized, but that such strategies lacked formalization and did not adhere to evidence-based or empirical practices. It was also indicated that formal plans, data collection practices, and the requisite policies supporting those services were under development.	N

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	in such a way that progress can be measured to determine the efficacy of treatment.	Due to the lack of treatment plans, it was not possible to review non-PBSP psychological services at RSSLC. As this provision calls for the provision of such services when the need has been identified, at the time of the site visit the Facility was not in compliance with this provision of the Settlement Agreement.	
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.	The Facility had a PBSP in place for each individual identified as requiring behavior intervention. Consents and approvals were typically obtained for PBSPs, restrictive procedures and the use of psychotropic medication. Many consents met basic time frames and procedural requirements, but several lapses were noted during the site visit. • For Individual #149, PST approval was obtained on 2/2/2010. Final HRC approval was not obtained until 4/8/2010. • For Individual #426, two months elapsed between the PSP and final HRC approval. One target of the PBSP for Individual #426 was pica. • For Individual #452, two months elapsed between the PSP and final HRC approval. One target of the PBSP for Individual #452 was physical aggression. • For Individual #525, the PBSP and consents were over a year old. One target of the PBSP for Individual #525 was pica. • For Individual #612, four weeks elapsed between the PSP and final HRC approval. • For Individual #678, six weeks elapsed between the PSP and final HRC approval. One target of the PBSP for Individual #678 was pica. • For Individual #770, the PST approved the PBSP on 6/28/2010. The HRC offered final approval on 8/16/2010. Written consent for the PBSP had expired on 1/10/2010. Intervention targets included in the PBSP for Individual #770 were self-injurious behavior (SIB) and physical aggression. The above examples reflect a trend toward substantial delay between the identification of the need for behavior intervention by the PST and final approval by all persons and groups. As many of the PBSPs involved in the above examples targeted potentially dangerous behaviors, the Facility is placing the individuals, their peers and Facility staff in prolonged risk by not acting prudently and promptly. The noted delays were due to delay in revising PBSPs after the PRC or HRC review, possibly due in part to lack of staff with demonstrable competence in developing PBSPs that meet current standards. RSSLC had made substantial progress in initiating training for Behavioral Services staff, but the training process was likely to require 18 to 24 months. If the Facility is unable to provide adequate treatment and protection for individuals residing at the Facility in the interim, then alternative provisions need to be implemented. Substantial deficits were also noted in the overall review, approval and monitoring	N

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		processes required to protect individuals living at the Facility from harm. This was most obvious in reference to Individual #448. Individual #448 had numerous medical conditions, including congenital heart malformations, heart valve regurgitation and a pacemaker, that could result in severe injury or death should the individual be subjected to physical exertion or distress. For these reasons, the application of any physical or mechanical restraint should have been attempted with extreme caution or avoided altogether. Despite these risks, the Facility failed to implement or follow the necessary precautions, as reflected in the examples below. • The Nursing assessment in PSP dated 4/13/10 states, "Interventions: Rest periods before and after periods of exertion like bathing, meals, physical activities, and treatments maintained; and vital signs monitored periodically." • Physician/Nurse Practitioner Assessment for Identifying Potential Health Risks for Restraint lists pacemaker, prone to have subluxation of cervical spine, Gastroesophageal reflux, and states, "Based on the medical condition(s) identified above, the IDT should consider the risk/benefit in determine if restraint should be use situation (sic) and put into place any safeguards to minimize the risk(s)." There was no documentation that the PST considered these. • A separate sheet in the Physician/Nurse Practitioner Assessment for Identifying Potential Health Risks for Restraint states, "For [Individual #448] the only approved restraint is 4-point if on the home and limbs held if off the home. Do not press on his chest. No basket hold or bear hug."—signed but not dated by physician. Restraint of 10/6/10 at 2:05 p.m. per Restraint Checklist was "Horizontal (Side-lying)." Restraint of 10/6/10 at 2:16 p.m. was "Physical hold-arm" and "Physical hold-leg." Restraint of 8/20/10 at 4:01 pm was also horizontal; Dr. Palter orders stated "May use emergency restraint of horizontal restraint" and gave the time of the restraints. • The PSP Addendum of 7/29/10 for 3 or more restraints in a rolling 30-day period, under Risk vs. Risk of Restraint, stated, "The PST is aware of the numerous restraints but find it necessary due to [Individual #448] aggression towards self, others and environment." This did not mention cardiac or other health risks. • The Consent form signed 4/17/10 stated, "A list of any supports considered to be restrictive or aversive is included in the attached table." No table was attached in the record. • The HRC review of PBS stated, "The only rights restriction is the medication he takes." There is no comment on use of restraint. Based upon the available records, it was evident that, despite the availability of information relating to personal health risks, the Facility did not institute the necessary precautions. As a result Individual #448 was subjected to several applications of	

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		restraint that had the potential to result in personal injury or death. Due to pervasive weaknesses in the assessment process, it is likely that limited understanding of the individual's treatment targets is gained and only minimal support for intervention strategies can be provided. • Zero of 36 records reviewed (0%) included results obtained from a process or instrument recognized as being able to identify potential functions of a behavior. • Zero of 36 records reviewed (0%) reflected the use of more rigorous or empirical procedures necessary to clarify potential functions and address limitations inherent to indirect functional assessments. • In 36 of 36 records reviewed (100%), intervention targets were presented and monitored as a group regardless of differing function, topography or other characteristics. Without comprehensive assessment, and the resulting poor support for provided interventions, it is unlikely that the information contained in the consent and approval documents is valid, that treatments for which consent and approval have been requested can be supported, and that those who have been requested to provide consent have been provided with adequate information upon which to base a decision. Specifically, informed consent requires that the consenter be provided with sufficient information about the proposed intervention to formulate a decision about whether or not to grant consent. In most situations, the consenter must be provided with the following information. • Implications of going without treatment and of treatment being postponed for different periods • The range of accessible diagnostic or treatment options • The benefits each option offers • The possibilities of diagnostic false results or treatment failures • The risks and discomforts of diagnostic or treatment options even when successful • Short-term injuries that diagnostic or treatment failures may cause • Long-term effects of diagnostic or treatment options, favorable and unfavorable, separating probabilities from possibilities It is the responsibility of the Facility to conduct the assessments essential for informed consent. Due to the limitations noted in the assessment and monitoring process, RSSLC had consistently failed to meet the obligation of providing sufficient information to the consenter. As a result, the Facility consistently failed to obtain valid and informed consent.	

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K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Many Behavioral Services and other staff acknowledged substantial weaknesses in behavior data. Despite such concerns, there was not any routine assessment of the actual quality of behavior data. Except in isolated cases that were verbally reported, there was no attempt to measure data reliability or interobserver agreement (IOA). In addition to limitations noted in data collection, the practices used in the compiling and graphing of treatment data at RSSLC continued to present substantial weaknesses. These weaknesses or limitations included the following. • In 36 of 36 records reviewed (100%), monthly data graphs presented data as the daily mean displays of behavior per week. Reporting daily mean frequency is inadequate as it fails to differentiate between behaviors that are presented in bursts and those that are displayed at a consistent low frequency, and does not provide a meaningful measure of behaviors that occur at high frequencies • In 36 of 36 records (100%), treatment objectives were stated in terms of total frequency while data were presented as daily mean frequency per week. • In 36 of 36 records (100%), progress notes and other data reports presented multiple data graphs for a single treatment plan. These data graphs typically did not share the same Y-axis scale. For example, the progress note for Individual #353 included four data graphs with four different Y-axis maximum values (.07, .30, .40 and 1.0). In order to allow comparisons of different measures on different graphs, it is essential that the Y-axis (the vertical axis on the graph) on each graph use the same scale of measurement. When the scale of measurement is different on each graph, much like having distance measured in inches on graph one and kilometers on graph two, comparisons cannot be easily made between the two graphs or data sets. • In 36 of 36 records (100%), no indications of treatment conditions were included. Without an indication of when a behavior intervention or psychotropic medication was started or changed, it is not possible to determine if that treatment produced a change in the treatment target. As a result of the issues presented above, it was not possible in the majority of cases to determine whether a PBSP or psychotropic medication was providing any benefit to the individual or even if it was causing harm. Substantial changes in data collection practices will be necessary for RSSLC to make progress toward satisfying this portion of the Settlement Agreement.	N
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	A review of 36 records reflected that many behavior interventions are written using complex language and technical terms. In some sections of a PBSP, such writing may be unavoidable. The specific intervention methods that direct care staff will be expected to implement should be written in a manner that is user friendly, easy to read and allows for quick and effective implementation. This was not the case with the majority of PBSPs	N

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	be understood and implemented by direct care staff.	and substantially limits the ability of staff to implement interventions correctly and efficiently. Observations regarding the length and complexity of the PBSPs were supported by recommendations offered in the most recent Peer Review Committee meeting. Written records from the meeting indicated that the PBSPs were found to be too lengthy or complex in 67% of submissions. At the time of the site visit, RSSLC did not routinely assess the implementation of PBSPs. It is well understood that the application of any process will drift over time. Without ongoing training and assessment of intervention integrity, it will not be possible for RSSLC to ensure that PBSPs are being implemented as intended and in a manner that is of benefit to the individual. A comprehensive system of treatment integrity checks and staff training must be implemented in order to meet the Settlement Agreement.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	At the time of the baseline visit in April, 2010, RSSLC indicated that a competency-based approach to staff training for PBSPs was not in place. During the baseline visit, it was both observed and reported that training on PBSPs in many residences consisted of being read or asked to read the intervention plan. Staff were then asked to sign a form stating that training had been conducted on the particular PBSP in question. Isolated examples of a more comprehensive training process were documented, such as in the Neches residence, but were not the norm. During the current site visit, the Facility reported that no changes had been made in regard to the provision of training to direct contact or non-Behavioral Services staff regarding interventions. The lack of staff familiarity regarding PBSPs was at times surprising. For example, in a discussion with Heather Blackwell, the Director of Vocational Services, Ms. Blackwell indicated that she was unaware of PBSPs for pica having been implemented for individuals working in the clean workshop. The clean workshop is a workshop deemed to be safe for individuals with pica due to the extra precautions taken to eliminate the presence of ingestible objects. Only people with pica work in the workshop.	N
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	At the time of the site visit, RSSLC employed one staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every individual residing at the Facility and fell far short of the required ratio of one BCBA for every 30 individuals. If all staff members currently working toward BCBA credentialing successfully earned board certification, the Facility would have one BCBA for every 24 individuals residing at the facility.	N

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	assistant for every two such professionals.	RSSLC currently employs 11 Psychological Assistants. This would be sufficient to meet the ratio of one assistant for every two BCBAs even if all qualifying positions were staffed by a BCBA.	

Recommendations:

1. The Facility needs to immediately review all individuals with serious health conditions to ensure that routine or emergency intervention procedures do not expose individuals to unnecessary risk.
2. The Facility should develop a plan to ensure that, until a substantial number of staff are demonstrably competent in applied behavior analysis, behavior assessments and interventions conform to accepted behavior analytic practices.
3. The Facility should review the current Peer Review Committee practices and implement the necessary steps to ensure that the peer review process operates under formal guidelines and produces objective and measurable benefits.
4. The Facility should review the consent and approval practices for behavior interventions and take the steps necessary to ensure that consent and approval adheres to mandatory time frames, allows for prompt implementation of behavior intervention and ensures that true informed consent is achieved.
5. The Facility should establish clear, formal guidelines regarding behavior assessment and intervention practices that conform to current expectations in applied behavior analysis and establish the necessary oversight to ensure that the guidelines are adhered to.
6. The Facility should act to ensure that the need for intellectual and adaptive assessment is recognized and that intellectual and adaptive testing is conducted and results used according to expectations.
7. The Facility should act to ensure that behavior assessment is formally integrated into the process for diagnosing and treating mental illness.
8. The Facility should review current practices regarding behavior assessment and intervention, and develop procedures that provide for interventions and outcome monitoring that emphasizes discrete behaviors or functional classes of behavior.
9. The facility should establish a data collection and presentation system that is individualized, ensures valid and reliable data, and facilitates the monitoring of treatment effects.
10. The Facility must act to ensure that PBSPs can be easily understood by those staff expected to implement the programs. Many factors affect program implementation, including staff academic history, reading ability, and fluency in English, as well as how easily the program can be reviewed during a severe behavior display or by a new employee who must review information quickly at the beginning of the work period. All of these factors must be addressed to ensure the PBSPs are implemented correctly.
11. The Facility needs to develop standards and procedures to identify when psychological services other than PBSPs are appropriate, how those services will be provided, what curricula or standard therapeutic procedures will be used, how fidelity of implementing those procedures by clinicians will be assessed, and how treatment effectiveness will be evaluated.
12. The Facility should develop and implement a system for ensuring that staff possess and use the skills necessary for formal and informal behavior intervention. This includes developing competence in the basics of applied behavior analysis, as well as knowledge of and the ability to implement PBSPs correctly. It is recommended that training be competence-based and that staff assessment and training be conducted on an ongoing basis.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI) 5/17/10 2. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10 3. Clinical records, including integrated progress notes, diagnostics, consultation, PSP and interim PSP of individuals #783, #694, #167, #478, #677, #747, #770, #140, #547, #369, #783, #694, #167, #478, #677, 683, #161, #377, #471, #407, #723, #124, #96, #471, and #390. 4. Draft policy for hydration 5. Draft policy for peer physician review 6. Infection control data base 7. Policy on mortality review 8. Policy on provision of physical therapy services 9. RSSLC Health Care Services, conducting Mock Medical Emergency Drills and Revised Form, Revised: 7/29/10 10. RSSLC Basic Life Support (BLS) for Healthcare Providers Training Manual, American Heart Association, 2006 11. RSSLC Mock Cardiopulmonary Resuscitation (CPR) Reports, 3/10 through 8/10 12. RSSLC Competency Training and Development Course Delinquency List for CPR Basic Training 13. RSSLC Emergency Medical Response Committee, 10/21/10 14. RSSLC Mock Medical Emergency Drill Sheets for Infirmary, at 12:02 p.m., 10/28/10 and at 1:55 p.m., 10/28/10 15. RSSLC Emergency Equipment Checklists (Automatic External Defibrillators, oxygen tanks, and suction machines) for all Units, 10/1/10 through 10/27/10 **People Interviewed:** 1. Charlene McCurry, Chief Nurse Executive (CNE) 2. Donald Pavliska, Competency Training and Development (CDT) Director 3. Karina Silva, CPR Instructor 4. Kay Galloway, RN, Nurse Recruiter 5. Wilma Parker, RN, Quality Enhancement Nurse 6. Robyn Partridge, RN, Quality Enhancement Nurse 7. Ambrose Banor RN 8. Gary Sandler, Director of Habilitation Therapies 9. Livia Erich, OT 10. Melissa Amores, PT 11. Brian Johnson, Residential Coordinator 12. Ebany Wuland, Home Supervisor 13. David Partridge, MD 14. Lelamma Francis, APRN 15. Irene Fuentez, MD

Comment [MJD1]: Are you talking about the ARNP? That is Leelamma Francis, ARNP. I don't know which physician is the new one. You can look at the names on page 82 of Document Request item Section ! #2 (table of organization). If it isn't one of them, I may have to leave it blank in the draft and ask for a name.

	16. Tran Quan, DO, Director of Medical Services 17. Robyn Partridge, RN, QA Nurse 18. Kelley Sandler, RN, Infection Control Nurse 19. Kimberly Randel, RN, Infection Control Nurse **Meetings Attended/Observations:** 1. Morning physician meeting, October 27, 2010 2. Observation of individuals served at all living areas at the Facility 3. Face to face observation of individuals #783, #694, #167, #478, #677, #747, 4. Meeting to discuss progress in reporting and monitoring of infectious control issues, October 25, 2010 5. Face to face observation of individuals #770, #140, #547, #369 6. Annual PSP meeting, October 28, 2010 7. Pt/OT meeting to discussion physical therapy services, October 28, 2010 8. Meeting with unit physician, lead nurse, unit PT, case manager , home supervisor and occupational therapist to discuss individual # 309, October 27, 2010 9. Checked Emergency Equipment (Automatic External Defibrillators (AEDs), oxygen tanks, and suction machines) in Trinity, San Antonio, Neches, and Leon, 10/28/10 10. Observed nurses' ability to operated Emergency Equipment AEDs, oxygen tanks, and suction machines) in Trinity, San Antonio, Neches, and Leon, 10/28/10 11. Check Emergency Medication Boxes in Trinity, San Antonio, Neches, and Leon, 10/28/10 12. Mock Medical Emergency Drill in Infirmary, at 12:02 p.m., 10/28/10
	Facility Self-Assessment: The Facility has made some progress in the area of Medical Services. The Medical director had established a new process to establish a local peer to peer chart review and has established new guidelines on skin infections and hydration. The Central Office is working with the Facility, and other Facilities, on developing clinical pathways for common and serious conditions for people with intellectual disabilities and comorbid medical conditions. The Medical Director had also developed a new method that will help to ensure that diagnostics are reviewed and acted upon. The Facility recognized that it is in the beginning stages of the overall enhancement process and is yet to find itself in compliance with Provision L of the Settlement Agreement.
	Summary of Monitor's Assessment: Following review of medical services, the monitoring team concurs with the Facility's self assessment and concludes that the Facility is not in compliance in Provision L of the Settlement Agreement. During the review period, the monitoring team noted progress in some areas of medical services. The monitoring team is pleased with progress made in developing work groups to address clinical pathways for common and serious clinical conditions. The initial phase of development of an infection control data base, policies for hydration, peer review process and superficial skin infections were also noted to be of benefit to individuals served at the Facility. Of concern, however, is the apparent slow progress in developing and implementing enhanced practice standards at the Facility.

	Important issues that must be attended to immediately include a comprehensive review of activities of the Advanced Practice Registered Nurse to ensure she is practicing within the legal limits of the Nursing Practice Act, that she is supervised according to provisions of the Medical Practice Act and most important, that her practice reflects her actual abilities and training. Although a Collaborative Practice Agreement had been prepared, it was unsigned, and the supervision required by the agreement was not consistently done. Physicians must be more comprehensive in their assessments and do their best to determine the etiology of conditions diagnosed by them. Clinical records and documentation practices remain a rate limiting area of concern for the Facility. Documentation should be comprehensive, include relevant negative and positive findings per physical examination, indicate the diagnosis or differential diagnosis, include review of relevant systems and outline the treatment plan and specific instruction to staff, as well as follow-up orders. The mortality review process is inadequate and must be revised. Since the baseline review the Facility had made improvement in their Emergency Medical Response System. Mock Emergency Medical Drills had increased from 30 drills to 90 drills per month in on each home and on each shift. The Facility had established an Emergency Medical Response Committee that met monthly to critique drill performance. The Infirmary staff failed the impromptu Mock Emergency Medical Drill as they had at the baseline review. However, the Infirmary staff were retrained and tested after the failed drill and completed the repeat drill successfully. There were 19 employees who were delinquent for two or more years in their Cardiopulmonary Resuscitation (CPR) Basic training. The version of the BLS Healthcare Providers Training Manual by the American Heart Association was dated 2006 and was four years old. The CTD Director needs to obtain and implement the latest version of the BLS Healthcare Providers Training Manual by the American Heart Association, reviewed and updated 4/8/10, to ensure that BLS training materials are up to date with current practice.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted	The monitoring team conducted an extensive review of medical services through direct observation of individuals served, review of clinical records, attending clinical meetings, discussions with clinical leadership and attending PSP meetings. Although progress was noted in many areas of medical services, this provision is not yet in compliance. Of particular concern of the monitoring team is the clinician's lack of insight into the clinical needs of individuals with developmental disabilities. Individuals served by the Facility have complex health care issues that are complicated by developmental anomalies and behavior challenges. The inability of individuals to self report signs and symptoms requires physicians to have additional expertise in this area . The monitoring team noted that the clinical staff at the Facility has had limited continuing medical education specific to developmental disabilities, which if offered, would enhance their ability to more appropriately diagnose and treat the many complicated health care issues	N

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	professional standards of care with regard to this provision in a separate monitoring plan.	experienced by individuals with developmental disabilities. The functionality of clinical records remains problematic. Locating important clinical data within the clinical record was a consistent problem for the monitoring team and is a barrier to clinical care. Documentation practice was also noted to be poor and did not foster a clear understanding of the individual's condition, follow-up to care and prescribed treatments. Documentation should be comprehensive, include relevant negative and positive findings per physical examination, indicate the diagnosis or differential diagnosis, include review of relevant systems and outline the treatment plan and specific instruction to staff, as well as follow-up orders. Physician, nursing and pharmacy staff commented that DADS is moving towards an electronic health care record (EHR); however, they report not being involved in the selection or development of the EHR and not having information on the pending EHR solution. A systemic and important issue at the Facility is the lack of integration of health care services into the team process. Clinicians depend on direct care and nursing staff to report clinical changes and concerns but they are not aware of staff limitations to appropriately assess clinical signs. As reported by the Advanced Practice Registered Nurse during a meeting with staff on October 29, 2010, clinicians often make diagnoses and prescribe treatments based on anecdotal reports by direct care staff, and without examining the individual. Following the visit, a clarification was provided that clinicians do not make diagnoses or prescribe treatment solely on report; this will require further review to determine what, other than report, is routinely done to make decisions on diagnosis and treatment. Importantly, the PST is not meaningfully made aware of clinical issues and as a result important and serious medical conditions are not incorporated into the PSP. During the annual PSP meeting for individual #747 on October 28, 2010, the entire PSP team that attended the meeting corroborated that clinical services is rarely incorporated into the PSP process. Importantly, they were unaware of many serious issues such as ischemic vessel disease and lacunar infarcts of the brain, a possible history of a myocardial infarct and the impact of hypertension in an African American Male. They were also unaware that the individual was a PPD converter and the importance of careful monitoring for tuberculosis. Also, the PSP was unaware of possible changes in the DISCUS and MOSES. Both the DISCUS and MOSES indicated no movement disorder, however, during the PSP the individual clearly demonstrated significant signs of a movement disorder that included lip smacking, mouth and tongue movements, slow perseverating speech and slow gait. Ultimately ,as a result, guardians were not fully made aware of clinical diagnosis, prognosis and many treatments offered by the Facility, and decisions on supports needed both currently and for movement to a more integrated environment	

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		were not based on complete information. Furthermore, risks related to the medical conditions may not be considered by the team when establishing services and goals. The monitoring team met with members of the Physical and Occupational Therapy (PT and OT) departments on October 26, 2010. The meeting was to evaluate physical and occupational services at the Facility. At the time of the review the Facility had four physical therapists, two physical therapy assistants, which are licensed and two positions that were opened for physical therapists (PT). At the time of the review, each PT had an active caseload of 80 individuals. The monitoring team recognizes the strong clinical leadership in this area. It is clear that the professional staff interviewed were knowledgeable and dedicated to their profession and individuals served at the Facility. As a result of the meeting and review of their clinical caseload, the monitoring team concluded that additional resources that include physical therapists, physical therapist assistants, clerical support and implementation of a meaningful EHR or specific data base solution would be helpful in achieving compliance. Observations made while visiting all of the living areas at the Facility indicated a high prevalence of musculoskeletal and servomotor conditions that were not identified by clinical staff. Because of limited PTs and PT assistants, only limited services were provided to individuals in need of service. The Facility did not analyze data on falls; although a spreadsheet was available (but not a data base), it was not useful in performing timely and thorough analysis. There was no active list of individuals who receive PT services nor to relate that list to people for whom such services are indicated (such as individuals who have begun to fall more often). There had been no outcome studies to conclude the benefit of treatment or need for continued treatment. The Facility did not maintain an active list of individuals with known musculoskeletal and neuromotor conditions, such as cerebral palsy, multiple sclerosis, and stroke, or other important clinical conditions. Being able to readily review active clinical conditions at the Facility is an important aspect of utilization review of medical practice. Of significant issue is the lack of a meaningful contracture management program; not one individual at the Facility had a Baclofen pump (Individual #783 is on oral Baclofen and has severe spasticity). PT and OT staff were aware of several individuals who had lost function and the ability to ambulate; many of these individuals had not had a meaningful medical evaluation that would help identify the underlying cause of their functional decline. For example, #783, #694, #167, #478, #677 were reported by PT staff to have sustained loss or significant reduction in their ability to ambulate and were without a definitive diagnosis. All such cases should undergo a comprehensive evaluation to determine the cause of their loss of function It is critical that the clinical staff be made acutely aware of what each clinical discipline is professionally capable of performing at the Facility. Following meetings with PT/OT services on October 26, 2010 and with the Facility's medical director and Advanced	

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		Practice Registered Nurse on October 29, 2010, the monitoring team determined that the various clinical disciplines at the Facility were unaware of important limitations of each respective discipline. In this particular situation, the monitoring team learned through interview of physicians and PTs/OTs that the physicians' expectations of services provided by PT/OT were beyond their scope of practice; in many cases, when physicians and the Advanced Practice Registered Nurse referred individuals to PT/OT for evaluation, they expected PT/OT to either make the diagnosis or provide service with an understanding of what the possible diagnosis is, while the PT/OT professionals had assumed that the physicians had diagnosed the condition and were requesting consultation for physical therapy. All professionals who provide clinical services, such as PT/OT, must ensure that each individual has been appropriately evaluated and a known diagnosis is made before recommending and implementing a treatment plan. It is incumbent upon the physician to diagnose the individual before requesting services. Review of clinical records indicates a systemic lack of comprehensive evaluation and follow-up on clinical issues. A specific case to delineate this issue is Individual #407, who died. Discussion with the treating clinician and review of medical records indicate that during approximately four months prior to death, this individual was noted to experience two episodes of pneumonia which resulted in hospitalization. The individual also experienced a rapid and serious course of functional decline and significant daytime somnolence. The treating clinician determined that the functional decline was the result of deconditioning. Although multiple imaging studies and neurology consultations were obtained, there was no physical assessment done to justify the diagnostics and consultation; instead, the clinician relied on reports by direct care staff. Given that the person experienced a serious and rapid loss of ability to ambulate and had a previous diagnosis of degenerative joint disorder of the C-spines with a reported "high probability of subluxation," an MRI of the spine was warranted. Also, specific recommendations to the neurologist were for "day time sleepiness," and there was no recommendation for assessment of loss of ability to ambulate. An additional case that was reviewed in detail by the monitoring team was that of Individual #390. In addition to reviewing this individual's clinical records, the monitoring team met with relevant clinical staff, which consisted of direct care, and nursing staff, the treating physical therapist and occupational therapist, home supervisor and the treating physician. This individual was known to have extreme behaviors that would result in self-injury and potential injury to others. Such behaviors were exacerbated by movement and abated at rest; however, the PST did not recognize this important factor. Such extreme behaviors usually indicate an underlying health care issues that results in pain and/or discomfort. The individual had known cervical spine disease, but there was no clinical follow-up to rule out worsening degeneration, which	

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		could easily account for loss of function and behavior exacerbation and possibly contribute to the individual's death. The individual also had a known diagnosis of GERD with enlarged rugae folds and history of gastritis and there was no indication of clinical follow-up for this condition. There was no clinical evaluation or reported differential diagnosis for the individual's abnormal balance and gait problem. The individual was noted to have worsening urinary incontinence that was attributed to his "stubbornness" and "just not wanting to go to the bathroom" and there was no clinical evaluation to rule out an underlying medical condition. The individual was noted to manifest prolonged and frequent periods of masturbation, which was contributed to his "behaviors." The individual was on medication that is known to delay ejaculation and causes such problems in men. A review of the individual's medications for this issue was not conducted or entertained by the clinical staff. The individual experienced two independent issues with regards to his ocular function. First, the individual was noted to have an oculogyric crisis, which was evaluated by a neurologist who reported that the condition was most likely secondary to his medication (Geodon). Instead of addressing the medication, the individual was continued on Geodon and he was treated with Cogentin, long-term to prevent recurrences. The PST did not discuss possible alternative treatment. The individual also was reported to have had at least four witnessed episodes of "staring spells," which as described by direct care and nursing staff were distinct from the oculogyric crisis and could possibly be secondary to recurrence of his underlying seizures disorder. The clinician staff did not entertain this issue. There was no follow-up on an abnormal EKG that demonstrated a possible left atrial abnormality and importantly, despite a warning by the Facility's pharmacist, the clinician continued short treatment with an antibiotic, Avelox, in conjunction with Geodon. The combination of these two medications must be used with caution; given a history of an abnormal previous EKG, a follow-up EKG and specific instruction to staff to monitor for clinical signs of cardiac manifestation should have been ordered by the treating physician. Importantly, the guardian should have been made aware of the risk involved with these two medications. In 2004 the individual was admitted to the hospital and diagnoses with asthma and reactive airway disease and was started on a Combivent inhaler for prophylaxis. Combivent prophylaxis was stopped for some while and there was no ongoing monitoring of his respiratory condition. The individual was known to have chronic constipation and was prescribed the medication Golytely; however, there was never an evaluation for constipation, no alternative therapies were offered, and there was no specific instruction for direct care and nursing staff to monitor nor were staff aware of this need. Golytely is a powerful anticonstipation medication that must be carefully monitored secondary to its potential to cause bowel perforation if the individual becomes focally impacted. The monitoring team had an opportunity to learn of the Facility's effort in developing a	

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		comprehensive method to track and manage infectious disease issues at the Facility through the development and implementation of a specific database for the tracking of infectious disease. The database proves to be a promising initial step in development of a comprehensive infectious diseases program. The monitoring team recognizes that all Facilities must ensure appropriate infection control practices with standards similar to that of long-term care facilities. <u>Emergency Medical Care</u> Since the baseline review the Facility had made significant improvement in their Emergency Medical Response System. The monitoring team checked all emergency equipment (AEDs, oxygen tanks, and suction machines) and nurses' ability to operate emergency equipment in Trinity, San Antonio, Neches, and Leon on 10/28/10. All emergency equipment was located in close proximity and readily accessible, clean, and in good working order. Nurses observed were able to successfully operate emergency equipment. This was a significant improvement since the baseline review. Emergency Packs for the Infirmary were completed in July, 2010 with all Infirmary nurses trained in their use as of 9/9/10. Otherwise, the Facility did not use emergency kits for emergency equipment as was recommended at the baseline review. The Emergency Medication Boxes were located in the Unit's medication rooms and were found locked and checked by the Pharmacy with current dates. All Units' Emergency Equipment Checklists were reviewed for completeness for October to date and were found completed daily/every shift as required. The Nursing Department needs to continue to ensure that all emergency equipment are checked daily/every shift. This demonstrated significant improvement from the baseline review. The Facility had adopted and implemented the revised Conducting Mock Medical Emergency Drill Policy, dated 7/29/10. Review of the CTD Course Delinquency List for CPR Basic Training indicated that 19 employees were delinquent for over two years. The Course Delinquency Lists for CPR Basic was regularly sent to the employees' supervisors. It is imperative that all employees remain current in CPR Basic training. The CTD Director and delinquent employees' supervisors need to ensure employees' who are delinquent in CPR Basic Training are brought up to date as soon as possible. The version of the BLS Healthcare Providers Training Manual by the American Heart Association was dated 2006 and was four years old. The CTD Director needs to obtain and implement the latest version of the BLS Healthcare Providers Training Manual by the	

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		American Heart Association, reviewed and updated 4/8/10, to ensure that BLS training materials are up to date with current practice. According to the Supplemental Plan of Improvement, all Infirmary staff were re-trained on Mock Emergency Medical Drills as of 9/9/10. Since the baseline review Mock Emergency Medical Drills had increased from 30 drills to 90 drills per month campus wide, on every home, and on every shift. Review of the Mock CPR Drill Reports, 3/10 through 8/10 indicated that all drills were completed quarterly. As required by policy, monthly trend analyses were completed. When deficiencies were identified they were documented on the monthly report along with recommendations for corrective action. Since the baseline review the Facility had established an Emergency Medical Response Committee. The first meeting took place 10/21/10. Committee members were comprised of the Donald Pavliska, CTD Director and Kay Gallaway, RN, Nurse Recruiter. Potential members for this Committee included Shannon Seales, Security and Risk Management. Review of the Emergency Medical Response Committee Minutes indicated that the Mock Medical Emergency Drills for August and September, 2010 were critiqued. It was reported that 90 drills per month were obtained. During the months of August and September, 2010, no deficiencies were noted. It was agreed that the Unit nurse was responsible for checking and maintaining all of the emergency equipment. It was reported that the Nurse Operation Officer had questioned the time it takes for the switchboard to relay that a drill was in progress to the campus nurse and campus coordinator. The campus nurse sometimes did not arrive until the drill was nearly completed. The Nurse Recruiter was to follow-up with the Nurse Operation Officer on the delay of the switchboard to notify the campus nurse and campus coordinator of the drills. The establishment of the Emergency Medical Response Committee was a positive finding and should facilitate improvements in the Emergency Medical Response system. The Emergency Medical Response Committee needs to develop and implement a written procedure to guide the Committee's functions. Committee membership needs to be broadened to include representatives from other relevant disciplines, particularly physicians. At the baseline review an impromptu Mock Medical Emergency Drill was conducted in the Infirmary which failed. According to the Supplemental Plan of Improvement nurses in the Infirmary were retrained after the failed drill. Another impromptu Mock Medical Emergency Drill was conducted in the Infirmary at 12:02 p.m. on 10/28/10. Unfortunately, the drill was failed. Areas failed included: Slow response with the oxygen tank and suction machine. Slow to call 4444. Staff did not respond immediately to scene when help was called for. The face shield was not called for and not used nor ambu bag. The nurse performing CPR did not give rescue breaths or reposition the head, use face	

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		shield or ambu bag. As a result of the failed drill a plan of corrective action was developed and implemented by the CPR Instructor and CTD Director that included: *Drill failed for above deficiencies. Director of Nurses notified. Meeting will follow with nurses to determine what went wrong as this is not characteristic of recent drills conducted at infirmary on this shift. It is recommending that staff involved be re-inserviced at next refresher, 11/4/10 at 1:00 p.m. – 5:00 p.m. Further corrective action at the discretion of the Director of Nurses.* The Emergency Medical Response Policy was followed as was demonstrated by immediately retraining and retesting the Infirmary staff after the failed drill. Another Mock Medical Emergency Drill was conducted in the Infirmary at 1:55 p.m. on 10/28/10. This drill was successfully completed.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	On October 27, 2010, the monitoring team met with the Facility's Medical Director specific to issues related to Provision L2. During the discussion, the monitoring team noted that the Medical Director had begun a review of the Facility's practice related to internal and external reviews of physicians and the delivery of health care services at the Facility. An untitled rough draft of a policy that describes a "chart peer review" process was reviewed. At the time of the review a comprehensive mechanism that includes a "non-Facility" peer review of physician services had not been developed. The Medical Director recognized the deficiency of L2 and will continue to improve the Facility's process, and ensure that it is consistent with State policy and the Settlement Agreement, is comprehensive in nature and assesses clinical practice and service delivery. Of particular concern to the monitoring team was the procedure under which medical care was provided by a Advanced Practice Registered Nurse at the Facility. After lengthy discussion with the Facility's Advanced Practice Registered Nurse, review of her case load and scope of practice that was without the physician supervision called for in the unsigned Collaborative Practice Agreement, the monitoring team concluded that enhanced supervision be immediately implemented and that medical leadership review her case load and ensure that she practices within a scope that is appropriate, given her level of training, licensure and certifications.	N
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services;	Following discussion with the Facility's Medical Director, the monitoring team was made aware that the Facility did not have a mechanism for assessing the quality of medical services. The Facility did not have quality assurance policies or procedures available in either formal or rough draft specific to medical services. The mortality review process was evaluated by the monitoring team and was found to be significantly deficient. The process consisted of two components, a clinical review and	N

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	assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	administrative review. The clinician reviews were cursory and did not comprehensively explore clinical care in an integrated way but instead focused only on the cause or possible cause of death. Little attention was placed on preceding care or on what recommendations for systemic change in medical care at the Facility might be made based on what was learned through the review. The administrative review, which was completed by the clinical records clerk, offered nothing more then a summary of services, such as a listing of consultations, diagnostics and treatments delivered by the Facility. The process afforded the Facility little opportunity to enhance their practice and services to other individuals at the Facility.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	During meetings with the Facility's Director of Medical Services, and review of email communication by the SSLC Medical Services Coordinator, the monitoring team was made aware of several promising advancements in the area of standard of care practice. Under the leadership of the DADS Clinical Coordinator, several important clinical conditions will be addressed in clinical pathways. Areas to be addressed include aspiration pneumonia, diabetes, metabolic syndrome, gastrointestinal disorders, obesity, nutrition, preventive disease, osteoporosis, seizure management, skin rashes, self injurious behaviors, PICA, Coumadin management and ambulation problems. At the Facility level, the Medical Director had identified superficial skin wounds, and hydration to be of particular concern for persons served by the Facility, and had subsequently developed rough draft protocols to address these issues. At the time of the review, the monitoring team concluded that the Facility had yet to implement new policies or practices, and that practice standards remained out of compliance with the Settlement Agreement. The monitoring team recognized the efforts made to enhance practice standards, and based on the coordination by the SSLC Medical Services Coordinator and the Facility Director of Medical Services, is hopeful that practice standards will be implemented in the near future.	N

Recommendations:

1. As with other Facilities reviewed, it is imperative that clinicians are provided a mechanism to benefit from continuing education, specific to the field of developmental disabilities.
2. Physician services must begin to re-evaluate individuals in their entire caseload and ensure that an appropriate and comprehensive diagnosis is applicable to the individual and that the etiology for each diagnosis is known. This falls under the domain of standard of care practice.
3. Documentation practices at the Facility must be immediately enhanced and strong consideration for the use of dictation or direct keyboard entry for physician notes should be entertained. Documentation should be comprehensive, include relevant negative and positive findings per physical examination, indicate the diagnosis or differential diagnosis, include review of relevant systems and outline the treatment plan and specific instruction to staff, as well as follow-up orders.

4. The delivery of clinical care must be better incorporated into an efficient and effective team process. The PST must be made aware of all clinical issues, treatments, diagnostics, consultations, prognosis, and alternative treatments available for each condition. It is imperative that the team carefully provides physicians and nurses with specific concerns and observations of the individual.
5. All clinical services at the Facility must immediately begin working together and better understand their specific roles, responsibilities and limitations. All clinical professionals must work within a clinical team concept. The primary care provider is responsible for coordinating all clinical services, including PT/OT, nutrition, speech and audiology services.
6. It is imperative that the use of Advanced Practice Registered Nurses (and physician assistants) at the Facility be reviewed to ensure that her caseload and scope of practice are reasonable and consistent with her level of training and ability. Her Collaborative Practice Agreement must be signed and followed.
7. For any individual who experiences "extreme" behaviors, an exhaustive evaluation for a possible underlying condition that can manifest in pain or discomfort must be sought. Physicians should work closely and ongoing with behavior specialists on such cases. Staff must be trained and re-trained to consider the possibility of physical and health issues contributing to problematic behaviors such as not wanting to ambulate or incontinence, and not to assume that such behaviors are related to stubbornness or laziness. Many times these types of behaviors indicate a serious underlying condition.
8. All cases of functional decline must require a prompt and comprehensive assessment to determine cause and to lead to intervention to minimize decline when possible. Specific to loss of ambulation, inclusion of a more comprehensive pathway to assess for "functional decline" (cognitive and physical) would be advantageous. Development of a screening program for functional decline will help identify subtle changes in ones ability and alert clinicians to search for reversible conditions before the condition becomes permanent and possibly life threatening.
9. The system should evaluate its current direction with regards to electronic health care records and evaluate a system that is capable of managing "primary care medicine, " one that is fully certified by the Commission for Health Information Technology, HIPAA compliant, and can integrate data base solutions from other sources, such as a program designed for the management of habilitation issues.
10. With regards to infection control practices, the Facility and other Facilities within the DADS system may want to explore external resources, such as those offered by the Association for Professionals in Infection Control. This organization offers industry standard information on the control and management of infection control issues at a significant value. Enhancement in infection control practices will have a positive benefit to individuals served by reducing the incidence of pneumonia, influenza, urinary tract infection and skin infections, as well as reducing the chances of contracting and spreading resistant organisms such as MRSA.
11. The Facility must immediately develop and implement an industry standard peer review process that involves "non-Facility physicians" in the review of physician performance and delivery of medical services to individuals served by the Facility. The process must ensure that the physician practice meets or exceeds current, generally accepted standards of care.It is essential that any review process established for "physician" services be extrapolated to all "clinicians" that provide medical services to individuals at the Facility, including Advanced Practice Registered Nurses and physician assistants.
12. The Facility must immediately develop an industry standard mechanism that ensures a robust quality assurance program is in place specific for medical services. A medical quality assurance process must include methods for selecting and analyzing meaningful data points, such as A1C values, metabolic syndrome, functional decline, aspiration and other pneumonias, bowel related complications, abnormal laboratory values, seizures and decubitus ulcers, and follow-up to care, and that data are routinely assessed and variances promptly attended to by medical leadership and the Facility. A data base should be utilized to track trends and evaluate efficacy.
13. It is essential that the mortality review process be immediately enhanced and conducted in a manner that is based on current industry standards, such as those adopted by hospitals and medical centers, that will enable the Facility to enhance medical services and better serve individuals in the future. It is important that the review process includes a trend analysis of the types and causes of deaths at the facility.
14. When developing clinical pathways it is essential to ensure that unique issues specific for individuals with developmental disabilities are incorporated into practice standards. Utilizing standard of care practices for the general population may not be sufficient to ensure quality

outcomes for persons with disabilities. Inclusion of an integrated approach will help ensure that all aspects of the individual's life will be attended to when developing a clinical pathway.

15. The Nursing Department needs to continue to ensure that all emergency equipment is checked daily/every shift.
16. The CTD Director and delinquent employees' supervisors need to ensure employees who are delinquent in CPR Basic Training are brought up to date as soon as possible.
17. The Competency Training and Development Director needs to obtain and implement the latest version of the Basic Life Support Healthcare Providers Training Manual by the American Heart Association, reviewed and updated 4/8/10, to ensure that training materials are up to date with current practice.
18. The Emergency Medical Response Committee should develop and implement a written procedure to guide the Committee's functions. The Facility should consider broadening Committee membership to include representatives from other relevant disciplines, particularly physicians.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI), 5/17/10 2. RSSLC Supplemental Plan of Improvement (SPOI), 7/5/10 3. RSSLC Nursing Department's Presentation Book 4. RSSLC Campus Map 5. RSSLC Organizational Charts 6. RSSLC Population Characteristics, 10/27/10 7. RSSLC Abbreviations 8. RSSLC Minimum Staffing for Nursing 9. Texas Department of Aging and Disability Services, State Supported Living Center Policy: Quality Assurance, Policy Number: 003, Date: 11/13/09 10. RSSLC Medication Observations completed by Quality Assurance Nurse, 9/28/10 11. RSSLC Summary of Texas monitoring Tools completed by Quality Assurance Nurse, 5/10, 6/10, 7/10, 8/10, and 9/10 12. RSSLC Automatic External Defibrillator Monitoring Reports completed by Quality Assurance Nurse, 10/13/10 and 10/14/10 13. RSSLC Positioning Monitoring Reports completed by Quality Assurance Nurses, 10/20/10 and 10/21/10 14. Records reviewed for individuals: #491, #7, #27, #499, #426, #57, #651, #84, #439, #285, #302, #150, #500, #283, #41, #95, #71, #390, #740, #583, #347, #217, #212, #320, #665, #649, #106, #571, #522, #586, #482, #303, #431, #415, #476, #619, #421, #27, #324, #454, #740, #6, #192, #154, and #407 15. RSSLC Nursing Schedule for all Units, 4/1/10 through 9/30/10 16. RSSLC Nursing In-services/Meetings, 4/1/10 through 9/23/10 17. RSSLC POI Training for Nursing Staff 18. RSSLC Documentation Training and Training Rosters, 8/10 a. Post Infirmary Documentation i. Policy E.16 – Post Infirmary Nursing Assessment ii. Nurse to Nurse Report b. Documentation i. Integrated Progress Notes ii. Health Care Issues in Integrated Progress Notes iii. Communication with Interdisciplinary Team iv. Errors/Mistaken Entry and Late Entry v. Initiation of New Treatment/Medication vi. SOAPE Format vii. Pain viii. Acute Illness and Injury

	ix. Emergency Room Visits and Hospitalizations c. Medication Administration and Documentation i. Medication Errors ii. Medication Pass Observation iii. G-Tube Medications iv. J-Tube Medications 19. RSSLC Monthly Paperwork (Check Sheet for Nursing) 20. RSSLC Nurse Manager's Monthly Chart Audits, 4/10 through 8/10 21. RSSLC Documentation Audit Forms (completed) and Associated Integrated Progress Notes, 10/10 22. RSSLC Texas Health Care Monitoring Tools (one completed for each monitoring tool), 9/10 23. RSSLC Nursing Monitoring/Audit Forms: a. Documentation b. Medication Administration Observation c. Medication Administration Records d. Med Room Survey e. MAR Audit f. Texas Health Monitoring Instruments for Nursing g. Emergency Competency Checklist h. Mealtime Observation Checklist i. Positioning 24. RSSLC Parenteral Sedation Intravenous (TIVA) Anesthesia Recovery Policy, Date: 6/1/10 25. RSSLC Nursing Procedure Manual: Nursing Notes/Infirmary IA-07, Infirmary Nursing Systems Review/Assessment, Revised: 7/29/10 26. RSSLC Nursing Procedure Manual, Transfer to community/Out of Town/State Hospital P-25, Not Dated 27. RSSLC Nursing Procedure Manual, Skin Integrity Management, IA-06, Revised 8/6/10 28. RSSLC Providing Health Care Services I.10: Admitting to Infirmary for Acute Care, Revised: 2/2/10 29. RSSLC Providing Health Care Services I.6: Providing Acute Health Care, Revised: 5/22/09 30. RSSLC Providing Health Care Services I.16: Monitoring Episode of Acute Illness/Use of Sedation, Revision: 6/20/10 31. RSSLC Nursing Procedure Manual, Neuro Protocol E-21, Neurological Assessment Protocol, Revised: 3/5/09 32. RSSLC Providing Health Care Services I.26: Prescribing Psychoactive Medications, Revised: 3/24/10 33. RSSLC Pre Treatment Sedation – Medical List 34. RSSLC Pre Treatment Sedation – Dental List 35. RSSLC Clients Using Bedrails List 36. RSSLC Incident Management Notes, 10/8/10 and 10/11/10 37. RSSLC Behavior Intervention J.1, Use of restraints, Revised 9/1/09 38. RSSLC Behavior Intervention J.2, Using Restraint in a Behavior Emergency, Revised: 9/1/09 39. RSSLC Behavior Intervention J.3.01, Using Restraint in a Safety Plan – Contingent Restraint, Revised, 8/1/08 40. RSSLC Behavior Intervention J.3.02, Using Restraint in a Safety Plan – Protective Restraint, Revised

	8/1/08 41. RSSLC Behavior Intervention J.4.01, Using Restraint During Medical/Dental Procedures, Revised: 8/1/08 42. RSSLC Behavior Intervention J.4.02, Using Restraint to Promote Healing/Recovery, Revised 8/1/08 43. RSSLC Behavior Intervention J.5, Using Restraint to Prevent Involuntary Self-Injury, 11/15/04 44. RSSLC Behavior Intervention J.6, Using Restraint to Provide Postural Support, Revised 11/15/04 45. RSSLC Unusual Incident Investigation Reports (for serious injuries since 5/1/10) 46. RSSLC Health Status List, as of 10/25/10 47. RSSLC Alphabetical list of individuals with current PSP dates, including dates for Annual and Quarterly Nursing Assessments 48. RSSLC Infirmary Admission Logs, 1/10 through 9/10 49. RSSLC List of Individuals seen at Emergency Center, 1/10 through 10/10 50. RSSLC New Admissions Since 4/1/10 51. RSSLC Clients Hospital Admission Log 2009 52. RSSLC Clients Hospital Admission Log 2010 (to date) 53. RSSLC Hospital Report, 10/26/10 54. RSSLC Swallowing Incidents, 7/30/10, 9/3/10, and 9/23/10 55. RSSLC Choking/PICA Incidents, 7/23/10, 8/23/10, and 9/20/10 56. RSSLC List of Pressure Sore Wounds (active) from 10/13/10 through 10/20/10 57. RSSLC Decubitus Report POI Data – Fiscal Year (FY) 2010 58. RSSLC Skin Integrity Committee Meeting Minutes, 4/7/10,4/28/10, 5/19/10, 6/9/10,6/23/107/14/10, 7/28/10, 8/11/10, 9/15/10, 10/13/10, and 10/27/10 59. RSSLC Nursing Role and Responsibilities Related to Each Section of the Settlement Agreement. 60. RSSLC Safety Committee Meeting Minutes, 7/14/10 61. RSSLC Pharmacy and Therapeutics Committee Meeting Minutes, 3/30/10 and 7/13/10 62. RSSLC Medication Error Committee Meeting, 4/29/10, 5/24/10, 5/27/10, 7/22/10, and 8/19/10 63. RSSLC Medication Errors and Pre-Sedation Data FY 2010 64. RSSLC Medication Administration Observation Reports and associated information, 3/10 through 7/10 65. RSSLC Infection Control Manual, Infection Control Policies and Procedures 66. Infection Control Manual, E.10, Reporting/Follow-up Procedure for all Individuals with Infections, Draft: 10/25/10 67. RSSLC Infection Control Access Database Description 68. RSSLC Infection Control In-service Training: Shower Mats/Shower Shoes, Target Audience: Unit Directors, Director of Residential Services, 7/21/10 69. RSSLC Quarterly Infection Control Meeting Minutes, 3/9/10, 6/29/10, and 9/21/10 70. RSSLC Analysis of Pneumonias Reported to Infection Control Department 4th Quarter (FY) 2010 (June, July, and August) 71. RSSLC Quarter Comparison Trends for Gastroenteritis, between 3/1/10 - 5/31/10, and 6/1/10 – 8/31/10 72. RSSLC Quarter Comparison Trends for Upper Respiratory Infections, between 3/1/10 - 5/31/10, and 6/1/10 – 8/31/10

	73. RSSLC Quarter Comparison Trends for Lower Respiratory Infections, between 3/1/10 - 5/31/10, and 6/1/10 – 8/31/10 74. RSSLC Infection Type Reported, 91/10 through 10/25/10: a. Gastroenteritis b. Lower Respiratory c. Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-resistant Enterococci (VRE), and Multi-Drug Resistant Organisms (MDRO) d. Pneumonia e. Sepsis/Fever of Unknown Origin f. Soft Tissue g. Urinary Tract Infection 75. RSSLC FY 10 4th Quarter Organism Reports 76. RSSLC Screening Questionnaire for H1N1 Flu Virus, Instructions for Supervisors 77. RSSLC Pandemic Respiratory Infectious Readiness Plan 78. RSSLC Handwashing and Infection Control Monitor Form (Quarter 4 FY10), June, July, and July 79. RSSLC Infection Control Manual E.10: Reporting/Follow-up Procedure for all Individuals with Infections, Draft: 10/25/10 80. Infection Control Training Materials: a. Ringworm b. Hepatitis B c. Hepatitis C d. Hand Hygiene e. Artificial/Native Nails Policy f. Infection Control g. Tuberculosis h. Cough/Sneeze/Running Nose Etiquette i. Rabies 81. RSSLC Infection Control Course Delinquency List, as of 10/26/10 82. RSSLC Infection Control Checklist – Blank Form (for Environmental Surveillance) 83. RSSLC Infection Control Rounds Reports for all Units, 5/10 through 8/10 84. RSSLC Infection Control Communication Logs, 9/25/1- through 10/1/10 and 10/10/10/ through 10/12/10 85. RSSLC Infection Control Training Rosters, 4/10 through 10/10 86. RSSLC Infection Control Committee Meeting Minutes, 6/29/10 and 9/21/10 **People Interviewed:** 1. Charlene McCurry, RN, Chief Nurse Executive (CNE) 2. Constance Bowie, RN, Nurse Operations Officer (NOO) 3. Adriano Soria, Jr., RN, Hospital Liaison Nurse 4. Kimberly Randel, RN, Infection Control Officer 5. Kelly Sandler, RN, Assistant Infection Control Officer 6. Ugo Nweke, RN, Nurse Educator

	7. Emma Purvey, RN, Infirmary Nursing Director 8. Wickiff Fawibe, RN, Skin Integrity Coordinator 9. Kay Galloway, RN, Nurse Recruiter 10. Wilma Parker, RN, Quality Assurance Nurse 11. Robyn Partridge, RN, Quality Assurance Nurse 12. Donald Pavliska, Competency Training and Development Director **Meeting Attended/Observations:** 1. Infection Control Database Presentation, 10/25/10 2. Medication Administration Observations in San Antonio C, 10/27/10 3. Skin Care Committee Meeting, 10/27/10 4. Medication Error Committee Meeting, 10/18/10 5. Unit Tours in Infirmary, Trinity, San Antonio, Neches, and Leon, 10/28/10 6. Emergency Mock Drill in the Infirmary, 10/28/10
	Facility Self-Assessment: RSSLC's Plan of Improvement stated noncompliance with this Section. Monitoring team concurs with the Facility's findings. Even though the Nursing Department had not achieved substantial compliance with this provision it was evident through interviews, observations, and document reviews that progress had been made toward compliance since the baseline review. The Nursing Department's Presentation Book was comprehensive and thorough in describing improvements and achievements accomplished since the baseline review. This was best demonstrated by the adoption and implementation of the Settlement Agreement Monitoring Tool used as a peer to peer process. The Nursing Department met their minimum staffing ratios without the use of agency nurses. The Nursing Staff had adopted, implemented and trained the Nursing Leadership, Nurse Managers and, and Nurse Case Managers on the Comprehensive Nursing assessment Guidelines and modified Form. The Infection Control Department had designed and implemented a new Access data base for tracking infections. An increased effort had been put forth in monitoring the administrations of medication.
	Summary of Monitor's Assessment: **Provision M.1:** The monitoring team did not find the Facility in compliance with this provision even though new policies and procedures were implemented and nursing staff trained since the baseline review. The Nursing Department was able to consistently meet minimum staffing ratios without the use of agency nurses. Nursing department has room for improvement in documentation, assessments, and notification of physicians promptly of acute illness and injuries. It was a positive finding that the QA Department and Nursing Department had adopted, implemented, and trained the Nursing Leadership, Nurse Managers, and Nurse Case Managers in the Settlement Agreement Monitoring Tools. Audits completed by the nursing staff used a peer to peer process. Use of the Tools began in July, 2010, and the Facility had not had enough time to analyze data to use for corrective action. **Provision M.2:** The monitoring team did not find the Facility in compliance with this provision. Although the Nursing Department had adopted, implemented, and trained the nursing Leadership, Nurse Managers, and Case Managers on the newly revised Guidelines for Comprehensive Nursing Assessment and

	accompanying form in July, 2010, not enough opportunities had occurred to demonstrate significant improvement in completing comprehensive nursing assessments for the monitoring team to find compliance. The implementation of the Comprehensive Nursing Assessment was a positive finding and, with experience, continued progress should be made toward compliance. **Provision M.3:** The monitoring team did not find the Facility in compliance with this provision. The Nursing Department had adopted, implemented, and trained the Nurse Managers, Nurse Case Managers and other nurses in July, 2010, on the Health Care Protocol for Developmental Disability Nurses to use for developing health care plans. However, not enough time had elapsed for the Facility to demonstrate significant improvement for compliance. The implementation of the Health Care Protocol for Developmental Disability Nurses was a positive finding and with experience continued progress should be made toward compliance. **Provision M.4:** The monitoring team did not find the Facility in compliance with this provision. Although numerous new policies and procedures have been developed, adopted, and implemented since the baseline review, the statewide nursing work group was continuing to develop other policies, procedures, and guidelines to improve nursing practices and to ensure compliance with the Settlement Agreement and Health Care Guidelines. As more policies, procedures, and guidelines are developed and implemented, progressive improvements should be made toward compliance. **Provision M.5:** The monitoring team did not find the Facility in compliance with this provision although numerous improvements had been made. The Infection Control Department worked collaboratively to develop a much improved database for tracking and trending infection control data. The purpose of this improved database system was to collect meaningful and valid data that can be utilized to trend over a designated date range as well as to quickly assist clinical staff in identifying emerging infectious issues so that the Facility staff can address them expeditiously. It was positive that the Infection Control Department had self-initiated a trends analysis for pneumonia. There remains much improvement to be made in preventing or control infectious disease process, particularly aspiration pneumonia. The Infection Control Workgroup had updated all Infection Control Policies and Procedures since the baseline review. **Provision M.6:** The monitoring team did not find the Facility in compliance with this provision. Significant progress had been made since the baseline review in an effort to improve medication administration practice and reduce or minimize the incidents of medication errors, as evident in reviewing medication error data. Medication Administration Observations for oral medication and enteral administration were completed monthly on nurses administering medications, and actions were taken as needed. The Medication Error Policy needs to be expanded to include all medication variances. The Medication Error System of analyzing and trending medication error data was not easy to understand and needs to be revised so it can be clinically useful. Although many systems had been implemented since the baseline review and much effort had been put forth by the Nursing Department in moving toward compliance, more time is needed for the systems to be

	refined and to mature before compliance with the Settlement Agreement can be achieved.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The Facility was not in compliance with this provision. Even though the Nursing Department had not achieved substantial compliance with this provision it was evident through interviews, observations, and document reviews that progress had been made toward compliance since the baseline review. The Nursing Department's Presentation Book was comprehensive and thorough in describing improvements and achievements accomplished since the baseline review. StaffingAt the time of the review the Facility had a census of 397. Since the baseline review the Nursing Department was able to consistently meet minimum staffing ratios without the use of agency nurses. The description of nursing staffing included: • A total of 112 Registered Nurses (RNs) with 110 of the positions filled and a total of 67 Licensed Vocational Nurses (LVNs) with 66 of the positions filled. • A total of eight administrative nursing staff, consisting of one Chief Nurse Executive, one Nursing Operations Officer, one Infection Control Officer, One Assistant Infection Control Officer, one Hospital Liaison Nurse, one Nurse Educator, one Nurse Recruiter, and one Skin Integrity Coordinator. • A total of seven Nurse Managers-- one Nurse Manager for each of the six units, and one Infirmary Director. • A total of 23 Nurse Case Managers for the six units with their caseloads ranging from approximately 14 to 20 individuals per caseload. • A total of 21 Campus Nurses who work out of the Infirmary. Three to seven Campus Nurses were scheduled on each shift. The Campus Nurses cover Three Rivers and Four Rivers on the 10 p.m. to 6 a.m. Shift, as these units were not staffed 24/7 due to the low acuity of individuals who reside in these units. • A total of 51 staff RNs for all shifts in the six units and the Infirmary, except for the 10 p.m. to 6 a.m. shift in Three Rivers and Four Rivers. • A total of 67 staff LVNs for all shifts in the six units, except for the 10 p.m. to 6 a.m. shift in San Antonio, Leon, Neches, Three Rivers and Four Rivers. • A total of three clinic nurses. • A total of two other LNVs. One LVN goes back and forth with individuals to the University of Texas Medical Branch in Galveston for off-campus appointments and one LVN serves as the Medical Clinic Coordinator. Review of RSSLC's organizational structure indicated that all nursing staff in the Units and the Infirmary report to the Chief Nurse Executive. The Chief Nurse Executive reports to the Assistant Director of Programs and is a member of the Management Team. This organization structure differed from most of the other State Centers where the Chief	N

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		Nurse Executive reported directly to the Facility Director. In most State Centers, the Chief Nurse Executive functions at the level of a Program Director because of the level of responsibility required by the Nursing Department. When the Chief Nurse Executives have a higher level of designation within the organization, they may have more leverage in the decision making processes of the Facility. Although structure of the organization is at the discretion of the organization, it is essential that the structure support both the establishment and implementation of high standards of care, and the integration of nursing within the interdisciplinary process. Because of the complex and multifaceted level of professional responsibilities, coupled with large professional nursing staff, the Facility needs to evaluate the Chief Nurse Executive's level of designation within the organizational structure. The Chief Nurse Executive stated that the Nursing Department was working with the University of Houston's School of Nursing to serve as a preceptor for Family Advanced Practice Registered Nurses and Psych Mental Practitioners in the fall of 2011. It was commendable that the Nursing Department was planning to serve as a preceptor to University of Houston's Collage of Nursing for their Family Advanced Practice Registered Nurses and the Psych Mental Practitioners because Schools of Nursing typically do not provide adequate training and clinical experience in the field of intellectual and/or developmental disabilities. The Chief Nurse Executive expressed concern with the Facility admitting more individuals with psychiatric problems. When individual with psychiatric problems need admission to the State Mental Health Hospitals, admissions were delayed and difficult to achieve due to limited bed space. She stated this will become more problematic over time as more individuals require psychiatric services. Additionally, the Facility's nursing staff needs more training in dealing with psychiatric issues. The Chief Nurse Executive stated that there was the need to continually evaluate staffing and other resource requirements as the Facility serves individuals with increasing psychiatric and behavioral issues as well as an aging population with co-morbid conditions. The Nursing Department needs to continually evaluate the need for additional staffing and other resources to meet the increasing needs of individuals served. <u>Training</u> Since the baseline review the Nurse Educator began providing competency-based training in July, 2010 on the recently adopted and implemented policies and procedures. To date 99% of the nursing staff received training as was validated by training rosters. Training was provided through classroom presentations, in-services, and small group training on each unit. The training included the following topics: • Comprehensive Nursing Assessment Guidelines and Form training was provided to all Nurse Managers and Nurse Case Managers. Use of the Comprehensive	

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		Nursing Assessment Form was initiated immediately after the training. Training continues on an on-going basis as questions arise or if clarification is needed or new nurses are hired into those positions. • Subjective, Objective, Assessment, Planning, and Evaluation (SOAPE) method of charting was begun on 5/6/10, with 100% of the nurses trained to date. Use of the SOAPE method of charting was implemented immediately after the training. The training was conducted on each individual unit in small groups and continues as questions arise or new nurses are hired. The Documentation Audit Tool was also used by the Nurse Managers, which provided additional opportunities for individual training if a particular nurse needs additional help. • RNIIs, RNIIIs, and RNIV were trained on the Health Care Protocols for Developmental Disability Nurses on July 1, 2010. • Care Plan Development training was provided to all of the RNIIs, RNIIIs, and RNIVs. • Seizure Record Form: All nurses were trained on the use of this form. • Medical Emergency Drill Checklist: All nurses were trained in the use of this form. • Post Anesthesia Care Protocol, all nurses were trained. • Settlement Agreement Health Monitoring Tools: Nurse Managers and Case Managers received training on these tools. • Documentation in the Integrated Progress Notes: All nurses were trained. • Additional Training: o Plan of Improvement Mass Training, August 16 and 17, 2010. Topics included all of Section M of the Settlement Agreement : ▪ M1 – Documentation ▪ M2 – Annual and Quarterly Nursing Assessments ▪ M3 Health Care Plans • Psychotropic Medications – Nursing Responsibilities ▪ M4 – Preventative Care • Pain Management • Acute Illness and Injury • Urgent, Emergency and Hospitalizations ▪ M5 – Infection Control and Case Management ▪ M6 – Medication Administration and Documentation o Physical and Nutritional Management training on Thickening Liquids and Thickened Distribution List for all homes, October 17, 2010 Review of the training materials and training rosters indicated that the Nursing Department had put forth significant effort in training the nursing staff in all aspects related to meeting compliance with the Settlement Agreement. As the nursing staff assimilate and gain experience with the trainings received progressive improvement	

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		toward meeting compliance with the Settlement Agreement should be achieved. <u>Quality Assurance – Peer Review Process</u> Since the baseline review the Quality Assurance Department had added an additional Quality Assurance Nurse. The Quality Assurance Nurses had adopted and implemented the use of the Settlement Agreement Tools in July, 2010. The Quality Assurance Nurses had begun analyzing and trending data outcomes from the result of their findings from the Tools. The size of sample was not determined. Data were represented in tabular, bar and pie charts forms. The summarized results of percentage of compliance found in each of the health related tools for September, 2010 are listed below: • Quarterly Nursing Assessment – 59% • Annual Nursing Assessment – 73% • Health Care Plans – 31% • Emergency Room and Hospital Visits – 50% • Hypertension Management– 64% • Seizure Management – 50% • Pain Management – 54% • Acute Illness and Injury Management – 35% • Aging Management – 25% • Diabetes Management – Not Applicable (none reviewed) • Gastroesophageal Reflux Disease (GERD) - 0% • Urinary Tract Infections - 0% • Bowel Management – 37% • Prevention – 18% • Restraints - Not Applicable (none reviewed) • Documentation – 60% • Skin Integrity Management – 100% • Respiratory Distress - % 71% • Psychotropic Medication Administration - Not Applicable (none reviewed) • Medication Administration – 70% • Infection Control – 100% In addition to using the Settlement Agreement Monitoring Tools, the Quality Assurance Nurses began monitoring Emergency Equipment and Positioning in the Units in October, 2010. Since monitoring of these items had just begun, the data were limited. The preliminary monitoring reports for Positioning revealed the following percentage of compliance with individuals' Positioning Plan: • Leon B – 85% • San Antonio – 82%	

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		• Trinity A and C – 73% It was a positive finding that the Quality Assurance Nurses had begun monitoring individuals' for positioning, particularly in light of the risks individuals have for aspiration and skin breakdown. The outcome of this monitoring will be reviewed again at the next tour. The Quality Assurance Department did not have policies and procedures in place for the use of the Settlement Agreement Tools, pending direction from the State Office. The Quality Assurance Nurses provided findings of the monitoring results to the Nursing Department. While data are being analyzed and trended, no formalized plans of corrective action had been developed at the time of the review, pending direction from the State Office. The Nursing Department adopted and and began implementing the Settlement Agreement Monitoring Tools in May, 2010 with full implementation in July, 2010. The Tools were used as a Peer Review Process. According to the Chief Nurse Executive the Tools were given to the Nursing Department by the State Office with little or no direction as to how to use them. Reportedly, the State Office said they were in the process of preparing training material in coordination with the Settlement Agreement Monitors but these materials have not been forthcoming, nor was there a procedure in place for the use of the Tools. A procedure for the use of the Tools was expected to be forthcoming from the State Nursing Policy and Procedure Committee, once more formalized training had taken place and the nurses have a better understanding of their use and intention. Some limited training on the Tools was provided to the Nurse Managers and Nurse Case Managers on August 16 and 17, 2010, in conjunction with training on the Plan of Improvement. Thus far, the nursing staff were just familiarizing themselves with the Tools. Therefore, they were not comfortable enough with the Tools and their understanding of parts of them to compose a useful trend analysis. The Chief Nurse Executive stated that when errors or substandard performance had been noted, Nurse Managers had trained and counseled nurses on an individual basis. This action was recorded as a "contact note" in the individual nurse's personnel file. In September, 2010 the Nurse Managers had completed two sets of the 24 Settlement Agreement Monitoring Tools. Copies of the completed Tools were available for review in the Nursing Department's Presentation Book. The Nurse Managers selected their own samples to audit. Review of the completed Tools found, with rare exception, the items contained on the Tools were marked "yes", unless the item was "not applicable". The Quality Assurance Nurse stated that in the future the Quality Assurance Department would select the sample for monitoring from a data analysis with list of diagnoses related to the Tools.	

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		As the Nursing Department gains more experience with the use of Monitoring Tools, instructions need to be developed and implemented for each tool as well as for establishing inter-rater reliability at 85% or above. Development of such procedures needs to be done in collaboration with the State Office to ensure that all Facilities use the same audit criteria and documentation to evaluate outcomes consistently across the state. The quality of the audit data must be taken into consideration to achieve substantial compliance. Simply having checked that an item on the Monitoring Tool was present does not necessarily determine compliance. Critical thinking must be applied to the item audited to ensure that the documentation reviewed or observations made meet the clinical needs of the individual and are in accordance with the Settlement Agreement and Health Care Guidelines. The Nursing Department needs to develop a Nursing Peer Review Committee that reviews and analyzes audit data derived from the peer reviews in an effort to identify and solve problems in nursing practice as a means to improve the quality of nursing services provided. As the process matures, data generated should facilitate improvements in nursing practice and begin to move the Nursing Department toward compliance with the Settlement Agreement. In addition to the implementation of the Peer Review Process with use of the Settlement Agreement Monitoring Tools, the Nursing Department conducted other audits that included: Medication Administration Observations, Medication Room Compliance, Medication Administration Record Audit, and Documentation Audits. The Nurse Managers completed documentation audits on all of the dorms in their Units, in addition to following up for inter-rater reliability on the audits conducted by the Nurse Case Managers. The Nurse Case Managers identified individuals with particular issues on their caseloads and used the audit tools to monitor for appropriate documentation and follow-up. Each Nurse Case Manager conducts four audits per month. Each Nurse Manager picks one audit from each of the Nurses Case Managers to audit for inter-rater liability. The Documentation Audits began in October, 2010; therefore, not enough data had been gathered from the audit to complete a meaningful trend analysis. There were no written procedures for the use of these audit tools. The Nursing Department needs to develop written procedures for each of the audit tools to ensure that audits are completed consistently by the various nurses conducting the audits. The Chief Executive Nurse related, thus far, that the most obvious improvements brought about by increased auditing have been in the areas of documentation, Annual and Quarterly Nursing Assessment, and care plans, although she admitted they were not in full compliance. Documentation Audits were validated through review of 17 completed audits. The completed Documentation Audit Tools also contained copies of the Integrated Progress Notes reviewed. When the Nurse Managers and/or Nurse Case Managers who completed	

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		the audits identified problems with documentation, there was documentation on the audit form indicating that corrective action was taken with the nurses committing documentation errors or problems with the quality and content of their documentation. This was a positive finding. The continued Documentation Auditing should move the nursing staff forward with improvements that will lead to substantial compliance with documentation. Documentation issues: • Documentation of time was recorded in the Integrated Progress Notes as both in military time and meridiem time. This made following timeframes in the records confusing. The Facility needs to standardize the method for which time is documented in the Integrated Progress Notes and other documents to ensure continuity and to avoid confusion. • Nurses' entries for time and/or dates were not consistently documented in chronological order in the Integrated Progress Notes. Often single entry documentation was written on an Integrated Progress Note with a line drawn through the remainder of the blank page, when the entry should have been written chronologically on the existing note. • Of the Integrated Progress reviewed, it was evident that the nurses were making progress in documenting in the SOAPE method of charting but need to continue to improve because entries were not yet consistently documented in the SOAPE format. Frequently, items were entered in the wrong acronym, e.g., objective measurements for vital sign were found documented in the P (plan) sections. • Documentation continued as was noted in the baseline review to be consistently illegible, particularly signatures and titles. For clinical data to be useful the reader must be able to read and understand the documentation. • The term "client" and "individual" were used interchangeably throughout the documentation reviewed. The Nursing Department needs to consistently use one term for continuity, preferably "individual, " when referring to Facility residents. • There were uses of terminology that lacked sensitivity. For example, contained in individual #476's Integrated Progress Notes on 7/9/10 at 10:30 p.m., "Pt. tolerated *feed* well," was used as opposed to stating that the individual was tolerating enteral nourishment well; on 7/10/10 at 0330, "*new bag of feed* set up" was used as opposed to "enteral nutritional formula was set up"; and on 7/10/10 at 0530, "*diaper* changed" as opposed to "adult brief changed." The Nursing Department needs to ensure that nurses use sensitive and professional terminology when documenting in individuals' records. • The nursing staff conducted mealtime observations as was demonstrated by review of Mealtime Observation Checklists completed on 9/14/10, 9/27/10, and	

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		9/28/10. The nurses used the Physical and Nutritional Management standardized form. Information derived from these observations was incorporated into the Annual and Quarterly Nursing Assessment. Beyond this use it was not possible to discern how these observations were incorporated and interfaced with the Physical and Nutritional Management Team (PNMT). This issue will be followed-up on the next review. • Often nurses failed to write in third person. The Nursing Department needs to ensure that nurses write in third person. <u>Acute Illnesses and Injuries</u> Through interview and review of individuals' records it was evident that the Hospital Liaison Nurse continued to visit all hospitals to which RSSLC individuals had been admitted every Monday, Wednesday, and Friday, and followed-up with phone calls on Tuesday and Thursdays, and more often if needed. These reports were updated on the Hospital Report Share drive, and documented in the Integrated Progress Notes. The documentation of the Hospital Liaison Nurses' notes was an improvement since the baseline review where the notes were only placed on the Share drive. Daily updates included general condition and status, vital signs, restraints, unit or hospital transfers, medications, diagnostics and lab test and/or other pertinent information. The Hospital Liaison Nurse coordinated with the interdisciplinary teams from the hospitals as well as the teams on campus in order to facilitate continuity of care on an individualized basis. The Hospital Liaison Nurse met with the nurses and doctors on a weekly basis at minimum, and with the Incident Management Team every Friday. A sample review of records for individuals' #491, #41, #6, #192, #154, #95, #283, #150, #303, #84, #285, #651, #439, #7, #390, and #71, who were admitted to the hospital over the past six months as well as review of the Hospital Report, 9/24/10 through 10/26/10, validated the Hospital Liaison Nurses' activities. The following provide examples of acute illnesses and findings of the monitoring team relevant to documentation and treatment: According to Integrated Progress Notes, on 7/23/10 at 11:35 a.m., the nurse documented the following information for individual #740, "*O*: *DCS called to report individual is complaining of ear ache. O/A: On assessment client setting on the sofa in the dayroom and pointing to her right ear,* [stating] *my ear is hurting." No drainage or swelling noted from the right ear. Vital signs T 97.8, P 84, R 18, B/P 119/90, O2Sat 97%. P: Tylenol 650 mg given PO, well tolerated. RTSC* [return to sick call] *in a.m. Instructed DCS to notify CN* [Campus Nurse] *incase for the complaint of pain. E: Will continue to monitor.* On 7/23/10 at 12:30 p.m. the nurse documented, *"S: ear ache – "my ear is hurting. It hurts when I eat." O/A: Individual ate lunch without difficulties. Ate 100% of meal. Voice that Rt ear is*	

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		hurting. Verbalized that she wanted to see the Dr. No drainage or erythemia, edema noted, skin warm and dry, B/P 115/62, P 78, R 18, T 98. P: Ibuprofen 800 mg PO c/o pain and will RTSC for further evaluation. On 7/24/10 at 11:20 a.m., individual #740 was seen in sick call and diagnosed with mild right ear otitis externa and prescribed Cortisporin otic, two to three drops twice a day for seven days. On 7/24/10 at 1130, the nurse documented, *"S: Individual stated "my right ear hurts me nurse." O/A: Individual awake and alert. Resp rate 20 even/unlabored no resp distress noted. C/o R ear pain no drainage noted no hearing loss problem noted. No c/o pain or discomfort from R ear. New orders received. Cortisporin 3 gtts R ear BID X 7 day DX Otitis. VS B/P 132/72 P78 O2Sat 99% T 97.8. P: ACP initiated. Will continue to monitor individual for change in condition.* On 7/24/10 at 1700 the Cortisporin otic drop were started with a report that individual #740 tolerated the medication well. Review of individual #740's Acute Care Plan was for Otitis Media as opposed to Otitis Externa (commonly know as swimmer's ear). The treatment for otitis externa differs from otitis media. The nurse developing the plan should have realized the difference and developed a plan specifically related to otitis externa. The plan was developed using the new Health Care Protocol for Developmental Disability Nurses. The plan was only slightly individualized. There were two items on the plan for intervention that were not applicable since they were not ordered and should have not been included in the plan, for example: Arrange for impedance measurement after three weeks of treatment. Have person perform Valsalva's maneuver several times daily to help open Eustachian tube as per PCP order. The follow-up plan for charting was at least once per shift during the acute phase (including vital signs and otoscopic assessment), then daily to resolution. The plan should have stated specific timelines for assessing and charting during the acute phase. Review of the Integrated Progress Notes for follow-up assessments and charting revealed the following findings: Assessments and documentation related to the otitis media were completed on 7/25/10 at 8:20 a.m., 7/27/10 at 8:00 a.m., 7/28/10 at 7:15 (a.m. or p.m. not included), 7/29/10 (time not documented), 7/30/10 at 7:00 a.m., 7/31/10 at 7 a.m., 8/9/10 at 9:55 a.m. (individual was seen in sick call and the physician determined the otitis external resolved), and on 8/9/10 at 0956 the nurse documented that the to Acute Care Plan was discontinued. The monitoring team included extensive documentation regarding individual #740's diagnosis and care for otitis externa to point out numerous concerns identified in reviewing the course of treatment and care: • The Acute Care Plan was developed for the wrong otitis diagnosis, e.g., for otitis media as opposed to otitis externa. The Acute Care Plan was not only for the wrong diagnosis but was not individualized to the degree necessary to meet the unique needs of Individual #740. For the most part it appear that the plan was simply copied from the Health Care Protocol for Developmental Nurses and used without thoroughly reviewing and thinking through the content and	

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		individualizing. While having protocols to use as a guide in developing care plans, nurses who use them must exercise their professional judgment to ensure that they meet the individuals' unique needs. The Nursing Department needs to continue providing nurses with training on the use of the Health Care Protocol for Developmental Disability Nurses to ensure that the protocols only serve as a guide for developing nursing care plans and should never be used wholesale without exercising their professional judgment to individualize the plans to meet the individual's unique needs. • Individual #740 began complaining of pain in the right ear on 7/23/10 at 11:35 a.m. but was not seen until 7/24/10 at 11:20 a.m., 24 hours later. According to the documentation, the individual complained several times of her right ear ache and even stated it hurt to eat. Otitis externa infections are very painful and require early diagnosis and treatment. The physician was not notified by the nursing staff of individual #740's ear pain when the complaints began; rather individual #740 was scheduled for sick call the next day. The Facility has physician onsite during the day and on call on the off hours. The nurses should have notified the physician and had the individual seen on 7/23/10. While an ear ache may not be life threatening, without an assessment of the ear using an otoscope, which was not done, the nurse had no idea of the origin of the ear pain. Had individual #740 had otitis media the ear drum could have been severely involved leading to a rupture of the ear drum which could have caused permanent damage to the ear resulting in hearing loss, hence, the importance on notifying the physician immediately when individuals complain of ear pain to ensure early diagnosis and treatment to relieve pain and prevent damage to the ear. The Nursing Department needs to ensure that when individuals have complaints of pain or discomfort that a thorough nursing assessment is completed by the RN and the physician promptly notified of the findings. The physician should make the judgment call as to whether the individual needs to be seen immediately or can wait to be seen in sick call the following day. • The Integrated Progress Notes relating to individual #740 were out of chronological order making it difficult to follow the clinical course of treatment. The Nursing Department needs to continue to monitor documentation and take corrective action to ensure that Integrated Progress Notes are written chronologically. Review of records for Individual #41 revealed that a series of six seizures began at 10:15 a.m. on 8/14/10. At 10:25 a.m. Diastat 10 mg was administered rectally. When the seizures continued the nurse notified the physician at 10:35 a.m., who then ordered another dose of Diastat 10 mg which given. At 11:00 a.m. the physician was notified again that the seizure activity had not stopped and orders were given to transfer	

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		individual #41 to the Oak Bend Hospital via Odyssey Ambulance Services. The exact time the individual was transferred to the hospital was not documented in the 8/14/10, Integrated Progress Notes. The nurse did document that copies of the seizure records were given to the Emergency Medical Services staff. The Campus Nurse, Nurse Case Manager, Client Services Duty Officer for individual #41 were notified of transfer to the hospital. There was no documentation regarding what if any transfer documents were sent to the hospital or what staff accompanied individual to the hospital. The nurse continuously monitored individual #41 during the seizures according to Seizure Policy. The revised Seizure Records were completed correctly for all six seizures. According to the Integrated Progress Notes on 8/14/10 at 9:30 p.m., individual #41 was admitted to the hospital for uncontrolled seizures. Individual #41 remained in the hospital until 8/18/10. The Integrated progress Notes indicated that the Hospital Liaison Nurse followed-up on individual #41's health status and kept the PST informed throughout the hospitalization. Prior to discharge there was documentation that a RN to RN Report was completed by the Hospital Liaison Nurse with the hospital nurse. Individual #41 was discharged on 8/18/10 and admitted to the Infirmary. There was documentation that an admission assessment was completed including a modified Braden Scale and Fall Risk Assessment. Individual #41 remained in the Infirmary for stabilization post hospital discharge. On 8/19/10 there was documentation that a RN to RN Report was completed between the Unit and Infirmary nurses. A PST meeting was conducted on 10/19/10 at 11:00 a.m. Individual #41 was admitted back to the Unit in stable condition at 11:30 a.m. Individual #41 was placed on medical monitoring for 72 hours, seizure and fall precautions. Acute Care Plan for Seizure Management was initiated upon admission for seizure management and there was evidence that the direct care professionals were trained. The Acute Care Plan for Seizure Management was resolved and discontinued on 8/25/10. Review of individual #41's care from the onset of the seizure episodes through hospitalization, admission to the Infirmary and return home met compliance with the Health Care Guidelines for acute care, with the exception of omitting documentation regarding time of actual transfer to the hospital, omission of documentation regarding transfer information, and who accompanied individual #41 to the hospital. This was a positive finding.	
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	The Facility was not in compliance with this provision. Even though the Nursing Department had not achieved substantial compliance with this provision it was evident through interviews, observations, and document reviews that significant progress had been made toward compliance since the baseline review. The Nursing Department's Presentation Book was comprehensive and thorough in describing improvements and achievements accomplished since the baseline review. According to the Chief Nurse Executive all Nurse Managers and Nurse Case Managers	N

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	status.	were trained on the Comprehensive Nursing Assessment Guidelines and accompanying Comprehensive Nursing Assessment Form on 7/29/10. Immediately after the training the use of the Comprehensive Nursing Assessment Form was implemented for annual and quarterly nursing assessments. Annual and/or Quarterly Nursing Assessment were reviewed on individuals #7, #57, #271, #390, #41, #439, #167, #583, #84, #302, #95, #285, #651, #71, #283, and #150. All 16 or 100% of the individuals' Annual and/or Quarterly Nursing Assessments were completed according to their Personal Support Plan schedules. All 16 individuals had a Braden Scale skin risk assessment completed on each of their Annual and/or Quarterly Nursing Assessments. Even though the Nursing Department had not met substantial compliance with the provision there was evidence of progressive improvement since the baseline review in both quality and substance of the assessment sections, including comment/summary sections related to relevant assessment items as well as in the nursing Summary sections. The most noticeable improvements were found in the annual and quarterly assessments completed after the implementation of the modified Comprehensive Nursing Assessment Form. Of the 16 individuals' Annual and/or Quarterly Nursing Assessments reviewed, for a total of 57 individual Annual and/or Quarterly Nursing Assessments reviewed, 15 or 26% were completed on the modified Comprehensive Nursing Assessment Form and 42 or 74% were completed on the older version of the Mental Retardation (MR) Nursing Assessment Form. The modified Comprehensive Nursing Assessment Form included assessment items that were identified as missing in the baseline reviews. Although, some improvements were found in the quality and substance of the assessments, the Nurse Case Managers need to continue to refine their skills in the following areas: • The summaries related to each of the Assessment Sections I through IX need to contained brief statements explaining the significant findings marked, as well as history when relevant. Clinical data that are no longer relevant should not be copied over and over from past annual and/or quarterly assessments. Response to care related to specific sections should also be summarized; this assists in writing the overall Nursing Summaries. • The Nursing Summaries for the most part contained more lengthy historical data but failed to analyze the data to clearly identify the individuals' health status related to each nursing diagnosis listed in the assessment section or the effectiveness of the related HMPs. Therefore, it was not possible to adequately determine if the individuals' health status related to their nursing diagnoses were progressing, maintaining, or regressing. Nor did the Nursing Summaries compare the individuals' health status from quarter to quarter as related to progress toward their measurable goals and objectives. While interventions	

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		carried out related to individuals' HMPs were to be documented in the Integrated Progress Notes and/or on other documents, it is only through good quality Nursing Summaries that the individuals' health status can be clearly identified. The Nursing Summaries provided the Nurse Case Managers and other relevant Personal Support Team (PST) members with critical health related information to use for evaluating the individuals' health status as well as for planning purposes. The Nurse Case Managers need additional training in analyzing and summarizing clinical data related to individuals' health status as identified in nursing diagnoses. • Often historical data was copied over from previous annual/or quarterly assessments and was no longer pertinent. The Nurse Case Managers need to critically evaluate what historical data are relevant to the current Nursing Summary and only include such data. Thoughtlessly copying over and over historical data that are no longer pertinent to individuals' current health status needs to be avoided and only serves to fill up the space that could better be used to include relevant clinical data. • Often several of the risk factors and/or nursing diagnoses were combined together into one nursing diagnosis as were their respective HMPs. These were complex risk factors and/or diagnoses and each need to have an independent nursing diagnosis and HMP because of their complexity to clearly delineate nursing interventions specific to each nursing diagnosis. • Often there were no nursing diagnoses and HMPs for all of an individual's high and medium risk indicators as well as for chronic conditions that were listed on the active problem list. • Often goals and objectives were stated as "nursing goals and objectives." In an integrated plan, they should not be stated as "nursing goals and objectives"; they are the individuals' goals and objectives and need to be stated as such. Furthermore, this should not be only a change in wording; nurses should participate in planning with the PST and should ensure their goals and objectives are part of an integrated plan. The following provide some examples of the concerns indentified in review of the Annual and/or Quarterly Nursing Assessments: • Quarterly Nursing Assessment, dated 7/1/10, for individual #740 indicated the following: o Section IV Nutrition and Weight Management: Individual #740 was 66 pounds above the desired weight range and was prescribed an 1800 calorie diet and had a Health Management Plan (HMP) for obesity. There was no summary statement regarding individual #740's documentation regarding	

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		the effectiveness or tolerance of the weight management plan. o Section VI History, Functional and Psychosocial: Individual #740 Trazodone 100 mg orally at bedtime for sleep. The sleep history check box was marked indicating that individual #740 takes sleep medication but there was no documentation in the summary regarding effectiveness of the medication or sleeping patterns. Pain History check box was marked "yes" indicating that individual #740 has pain and received pain medication. The summary statement indicated that individual #740 had chronic back pain from a history of mild herniated disc disease but the summary failed to indicate the frequency pain medication was administered and the effectiveness of the pain medication, e.g., Ibuprofen 800 mg orally every 3 hours as need for pain, to relieve the pain. The check box was marked that individual #740 had hypertension but there was no summary statement regarding the status of the blood pressure readings or the effectiveness of the antihypertensive medication, e.g., Amiodipine 5 mg orally every morning and Cervedilol 2 mg orally twice a day, in controlling the blood pressure. o Section X Nursing Problems/Diagnosis: Individual #740 had the following nursing diagnoses with accompanying HMPs: Hypertension – Blood pressure managed with Amiodipine and Coreg, Risk for Extrapryamidal (EPS) – Lithium ER, Depakote ER, Seroquel XP, Prozac, Trazodone, and Cogentin, Hypothyroidism – on Synthroid daily, Constipation – on Metamucil, and Obesity – 66 pounds above desired weight range. The Nursing Summary stated the following: [Individual #740] *has been medically stable this quarter.* [Individual #740] *is alert, oriented and able to communicate her needs.* [Individual #740] *has Hx of self injurious behavior and aggression towards self and others.* [Individual #740] *has episodes of pocketing medication and she is being monitored after medication administration. She continues to participate in SAMS program.* [Individual #740's] *recommended DWR 130-165 Lbs. Her current weight is 223 Lbs, and she is 58 Lbs above her desired weight range. Her diet has been reviewed and exercise has been incorporated into her routine.* [Individual #740] *has been seen in sick call for minor issues and lab reviews. She will continue to be followed closely by Psychiatry, optometry, ophthalmology and other healthcare professionals to monitor here health status. HMPS reviewed and will continue on DX. Hypertension, Schizoaffective Disorder, Disc Disorder, Hypothyroidism, and Constipation.* The Nursing Summary failed to summarize individual #740's health status as related to each of the nursing diagnoses or the effectiveness of the HMPs. The therapeutic responses to prescribed medications, particularly	

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		psychoactive medications, were not described. The summary only mentioned that individual #740 continued to participate in the Self Administration Program but failed to state what progress, if any, individual #740 was making in relation to the program. From review of this summary it was not possible to determine individual #740's progress or lack of progress toward established health goals and objectives. • Quarterly Nursing Assessment, dated 5/11/10, for individual #217 indicated the following: o Individual #271's Health Risk Score Ratings, 10/6/10, were listed as: high for Aspiration, medium for Cardiac, medium for Choking, medium for Dehydration medium for Gastrointestinal concerns, medium for Injury, medium for Osteoporosis, medium for Urinary Tract Infections, medium for Weight, and overall risk high. Review of individual #217's Quarterly Nursing Assessment, 5/11/10 revealed the following findings: o Section IV Nutrition and Weight Management: Individual #217's desired weight range was 85 – 115 pounds, with a current weight of 80 pounds, resulting in 4 pounds below the desired weight range. Diet/texture: Low Cholesterol, Low saturated Fats (Egg Substitute) Dietary Reflux Precaution, Double Portions (no grits, no oatmeal, no cream of wheat, no cream of rice, instead give mashed potatoes) Pureed Texture. Fluid/Consistency: Liquid of Honey consistency. The last date meal was monitored by the nurse was 5/3/10. Individual #217's nutritional risk included reflux, GERD precautions, non-ambulatory, and dysphagia. There were no summary statements regarding health status related to individual #217's nutritional and weight management issues. o Section V History and Psychosocial: This section included a comprehensive summary related to medical history. However, the Functional Status Section did not include a summary statement relating to items marked in the check boxes, e.g., Non Ambulatory, Positioning Schedule, Contractures, Non Verbal, PNMP Current, Wheelchair, Uses Briefs/Incontinent, and Self Injurious. Including a summary statement regarding these items assists in analyzing and formulating individual #217's health status related to functional status and effectiveness of treatment plan when writing the Nursing Summary. o Section X Nursing Diagnosis include the following information: ▪ [Individual #271] *has an Health Management Plan for Constipation open on 3/8/08;* [Individual #271] *is on medication that causes constipation and is also on medication to prevent*	

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		Constipation. ▪ [Individual #271] *has a Health Management Plan for injury & fall r/t Scoliosis open on 3/8/08;* [Individual #271] *has a history of pressure area.* [Individual #271] *also is transferred by Arjo Mechanical Lift.* [Individual #271] *has a diagnosis of Osteoporosis.* ▪ [Individual #271] *has an HMP for Ineffective Airway Clearance r/t Seizure Disorder;* [Individual #271] *at present time is not on medication for seizures.* ▪ [Individual #271] *has an HMP for Aspiration opened on 3/3/08;* [Individual #271] *has a diagnosis of GERD.* ▪ [Individual #271] *has an HMP for Low weight which was revised on 3/26/09*[Individual #271] *weight is below her DWR.* ▪ *I will continue HMPs.* o Section XI Nursing Summary: The majority of the summary included information copied from the past two quarters which was a historical summary of past events. The summary contained medical care received throughout the quarter. The summary stated that individual #217 participated in the SAMS Program and described the program but failed to indicate the status of progress toward achieving established goals and objectives. There was a brief summary of raw data related to individual #271's Primary Nursing Goals, e.g., Weight, Aspiration, Fall/Skin Integrity, Injury, Bed Rails, Constipation, and Seizures. This information failed to analyze progress or lack of progress in response to the HMPs and their effectiveness. There was no information in the summary regarding health risk factors related to Dehydration, Cardiac, Urinary Tract Infections, or Gastrointestinal. Nor were there Nursing Diagnoses and HMPs included for Cardiac issues and Urinary Tract Infections. A positive finding was signed Training Rosters validating that the direct care professionals were trained on the HMPs. From review of this summary it was not possible to determine Individual #740's progress or lack of progress toward established health goals and objectives. There was concern that the several of the risk factors and/or nursing diagnoses were combined together into one nursing diagnosis as were their respective HMPs. These were complex risk factors and/or diagnoses and each needs to have an independent nursing diagnosis and HMP, because of their complexity, to clearly delineate nursing interventions specific for each nursing diagnosis. Further, goals and objectives should not be stated as "nursing goals and objectives"; they are the individuals' goals and objectives and need to be stated as such.	

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		Nurses need to write in third person. The Nursing Department needs to ensure that there is a nursing diagnosis and HMP for all medium and high health risk levels as well as for other chronic health conditions that are listed as active medical problems. • Annual Comprehensive Nursing Assessment, dated 9/17/10, for individual #41 indicated the following: o Individual #41's Health Risk Score Ratings, 9/9/10, were listed as: medium for Challenging Behaviors, medium for Osteoporosis, medium for Respiratory, and medium for Seizures, o In general the use of the Comprehensive Nursing Assessment Form for individual #41's annual nursing assessment demonstrated improvement from the previous assessment completed in past quarters. There continues to be a need for improvement. o The summary statement related to Section I through IX were very limited and did not reflect substantive information according to findings marked in the check boxes. o Section X Nursing Problems/Diagnosis contained the following nursing diagnoses: ▪ *Risk for ineffective airway clearance/pain related to reflux or aspiration.* ▪ *Risk for decrease in normal frequency of defecation or impacted stools related to mechanical and physiological factors.* ▪ *Risk of fall/injury related to Osteoporosis.* ▪ *Risk for weight changes, constipation and hair loss related to deficiency of thyroid hormone.* ▪ *Risk for extrapyramidal side effect related to use of antipsychotic meds.* ▪ *Risk for decreased cardiac output related to high cholesterol.* ▪ *Reviewed and revised HMP, except for risk for decreased cardiac related to high cholesterol, this was newly implemented.* o Section XI Nursing Summary: The initial statement on the summary stated individual #41 had, "*Achieved the goal of having the best possible health."* Then the summary went on to list multiple health issues encountered throughout the year. Just to list a few, health issues included: Multiple sick call visits for a skin lesion on the buttocks, viral gastritis and fecal impaction, nasal drainage and vomiting, big toenail infection and upper respiratory infection, sinusitis, hospitalizations for Septic Syndrome, high ammonia levels. The individual had numerous behavioral issues such as rectal digging and refusal to take medication.	

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		The summary did include a brief summary according to individual #41's HMPs: ▪ *No injury/fall the past year.* ▪ *No extrapyramidal symptoms of using psychotropic medications.* ▪ *Had episode of constipation the past year.* ▪ *No episode of reflux/aspiration related to GERD.* ▪ *Metabolic state are (sic) in normal condition with evidence of normal level of total serum thyroxine dated, 5/10/10.* ▪ *Risk for decreased cardiac output related to high cholesterol, on medication.* ▪ *Weight loss occurred after hospitalization. DWR 120-150lbs, and current weight 120 lbs. Diet changed to promote weigh gain.* ▪ *Risk for impaired d/c had episode of big toenail avulsion the past year period and minor skin lesion. I will continue to monitor* [individual #41] *according to Health Management Plan.* o Therefore, it was questionable how individual #41had the best possible health over the past year with the history described. In general the Nursing Summary contained information regarding individual #41's past year medical history as opposed to analyzing health status as related to the effectiveness of HMPs, progress or lack of progress made toward established goals and objectives. It was evident through review of the Annual and Quarterly Nursing Assessments that the Nursing Department had not yet had time to refine their skills to complete a more comprehensive assessment with an effective analysis of individuals' health status. The Nursing Department needs to continue to reinforce training on the Comprehensive Nursing Assessment. Review of individuals #740 and #167s' Admission Nursing Assessments were completed within 30 days of admission, according to Facility policy.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual	The Facility was not in compliance with this provision. Even though the Nursing Department had not achieved substantial compliance with this provision it was evident through interviews, observations, and document reviews that progress had been made toward compliance since the baseline review. The Nursing Department's Presentation Book was comprehensive and thorough in describing improvements and achievements accomplished since the baseline review. According to the Chief Nurse Executive the Health Care Protocols for Developmental Disability Nurses was implemented in July, 2010. She stated that the books had been on	N

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	is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	back order since June 1, 2010, and was not sure why it was taking so long. However, the Nursing Department had been able to obtain a zip drive with these protocols on it from the company, and these were all in the Share drive for easy access by the nurses. She explained that the RNIIs, RNIIIs, and RNIVs were responsible for the initiation, coordination, modification, and follow-up of the Health Management Plans (HMPs) and Acute Care Plans (APCs), with the bulk of the responsibility for coordination falling on the Nurse Case Managers. LVNs were also involved in implementation, along with the RNs. The nurses on the units in-serviced the Unit Specialist and the Residential Coordinators on the HMPs and ACPs; these staff then signed the Signature Sheets and attached them to the care plans. It was the responsibility of the Unit Specialists and Residential Coordinators to in-service the direct care professionals. The Signature Sheets were used as validation that the in-service had been completed. The nurses assessed the direct care professionals' competency as they performed their other duties. If they observed any problems with care or direct care professionals' responsibilities in the implementation of care plans, those staff were retrained as needed. The Chief Nurse Executive provided a note of barrier to care: *Direct care staff are seldom compliant with nursing efforts to correct errors in care of the individuals, and many, campus-wide, will respond with "you're not my boss; you can't tell me what to do." Unit Directors are not holding them responsible for this, despite continual voicing of concerns in this area by nurses.* Reportedly this had happened on a limited basis in specific areas. The failure of the direct care professionals and the Unit Directors to ensure a harmonious working relationship was a concern because lack of cooperation presents a barrier to care and was not conducive to providing integrated services. However, following the visit, the monitoring team was informed that a committee had been formed to address this communication concern, made up of nurses and direct care professionals and chaired by the Director of Residential Services. According to this information, nursing had the full cooperation of the Unit Directors and Director of Residential Services. The results of the committee working to address the communication concerns identified above will be follow-up at the next tour. The Facility Director needs to ensure that there is a harmonious working relationship between the residential staff and nursing staff. It was of further concern that the nurses only trained the Unit Specialists and Residential Coordinators. This was poor practice. The Unit Specialists and Residential Coordinators are not qualified to train and evaluate direct care professional staffs' knowledge and skills for complex health care issues. The Nursing Department needs to cease the practice of only training the Unit Specialists and Residential Coordinators on the HMPs and ACPs and assign the nursing staff on each shift the full responsibility for training direct care professional staff to competence on HMPs and ACPs. The Nursing Department needs to ensure that the protocols adapted from the Health Care Protocol: for Developmental Disability Nurses are individualized to meet the unique needs of individuals, that nursing staff are retrained in its use, and when used ensure that the nurses follow the protocols as a guide for standard of practice; it does not negate the	

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		nurses need to exercise professional judgment. The monitoring team reviewed Health Management Plans (HMPs) and Acute Care Plans (ACPs) for individuals #7, #57, #271, #390, #41, #439, #167, #583, #84, #302, #302, #95, #285, #651, #71, #283, and #150. The plan consisted of a mixture of the older generic care plans and the one developed from the Health Care Protocol for Developmental Disability Nurses. Some improvement in quality was found with the use of the new protocols and more were beginning to be individualized. However, most continued to be copied and used with little or no thought as to the applicability of the content to the individuals' unique needs. The following example demonstrated the need to individualize health care plan: Individual #217's HMPs for Dehydration, dated 3/9/09 and revised 3/9/10, revealed the following information: Nursing Intervention included: 1. *Nurse is to do lab values and report increased levels to Doctor.* 2. *Nurse and DCS are to increase PO fluid intake.* 3. *DCS is to report to Nurse when* [individual #271] *is not eating and drinking.* 4. *Nurse is then to assess* [individual #271] *for dryness of mouth & mucous membranes, poor skin turgor, chills, dry skin, loss of appetite, dry mouth, dark urine, fatigue or weakness, increased heart rate, increased respiration, nausea, decreased urination and skin flushing and notify the Doctor when indicated.* 5. *DCS to provide good oral hygiene.* 6. *Nurse to document all findings on Integrated Progress Notes.* Individual #271 had a history of dehydration and a medium Health Risk Assessment for dehydration. The revised HMP for Dehydration was developed before the use of the Health Care Protocol for Developmental Disability Nurses was implemented. When revised it simply seems to only have had the date changed as opposed to content. This HMP was still current and was found to be most inadequate for assessing and managing dehydration. Asking the direct care professionals to let the nurses know when an individual #271 was not eating and drinking, and then the nurse assessing for dryness of mouth and mucous membranes, poor skin turgor, chills, dry skin, loss of appetite, dry mouth, dark urine, fatigue or weakness, increased heart rate, increased respiration, nausea, decrease urination and skin flushing is too late to prevent dehydration. By the time individual #271 is exhibiting these signs and symptoms, individual #271 would be in a state of full blown dehydration and require medical interventions, such as hospitalization for intravenous fluids. A prudent plan of care would be to collaborate with the Dietitian to establish the daily fluid requirements for individual #271 and to schedule and monitor fluid intake by using an intake and output tracking sheet. It is the	

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		nurses' responsibly to ensure that the prescribed amount of fluid is provided and monitored as well as assess urinary output and any other signs and symptoms of dehydration. It was difficult to understand what was meant by "*Nurse is to do lab values and report increased levels to Doctor'*. It is an interdependent role that the nurse has for ensuring that ordered lab work is completed and the results made available to the physician. The plan failed to state what lab work would be completed and it was questionable why only the increased lab values would be reported to the physician. This HMP, as stated before was grossly inadequate to meet the needs of individual #271 to prevent dehydration and needs to be revised to ensure that a cogent plan of care is established. Although the HMP for Dehydrated was inadequate, it was positive to find that direct care professionals had been trained in the HMP as was validated through review of the Training Roster.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	The Facility was not in compliance with this provision. Even though the Nursing Department had not achieved substantial compliance with this provision it was evident through interviews, observations, and document reviews that significant progress had been made toward compliance since the baseline review. The Nursing Department's Presentation Book was comprehensive and thorough in describing improvements and achievements accomplished since the baseline review. The Chief Nurse Executive participated with the Statewide Nursing Workgroup to develop Nursing Policies and Procedures to be used by all State Supported Living Center nursing staff. The Nursing Department had adopted and implemented the following State Policies: • Nursing Services Policy – December, 2009 • Care Plan Development – July, 2010 • Communication with Hospitals and Other Acute Care Facilities – August, 2009 • Weight Management – August – 2009 • Nursing Competency Based Training – August, 2010 • Self Administration of Medications – August 2009 • Comprehensive Nursing Assessment Guidelines – July, 2010 • Medication Errors – November – 2009 • Post Anesthesia Care Protocol – June 2010 • Lippincott Manual of Nursing Practice, 9th Edition – September, 2010 • Health Care Protocols for DD Nurses – July, 2010 • Additional facility-wide State Policies implemented: o 001 Restraint Policy – Revised 8/31/09 o 002 Incident Management – Implemented/Revised 6/18/10 o 003 Quality Assurance – Implemented/Revised 11/9/09	N

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		o 004 Personal Support Plan Policy – Implemented/Revised 7/30/10 o 006 At Risk Individuals Policy - Implemented/Revised 10/5/09 o 007 Psychiatry Services - Implemented/Revised 7/20/10 o 008 Psychological Services - Implemented/Revised 11/13/09 o 009 Medical Care Policy - Implemented/Revised 7/28/10 o 012 Physical Nutritional Management - Implemented/Revised 12/17/09 o 013 Nutritional Management Team – Implemented/Revised 1/31/10 o 014 OT PT - Implemented/Revised 10/7/10 o 015 Dental Policy - Implemented/Revised 8/17/10 o 016 Communications - Implemented/Revised 10/7/09 o 018 Most Integrated Setting - Implemented/Revised 3/31/10 o 020 Recordkeeping - Implemented/Revised 3/5/10 o 021 Protection from Harm, Abuse, Neglect, and Exploitation, dated 6/18/10 o 042 Video - Implemented/Revised 6/11/10 o 044 Medical Emergency Response Policy - Implemented/Revised 7/21/10 o 046 Serious Event Notification Policy - Implemented/Revised 9/1/10 As these policies, procedures and guidelines are implement and have time to mature the overall nursing practices should show progressive improvement.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The Facility was not in compliance with this provision. Even though the Nursing Department had not achieved substantial compliance with this provision it was evident through interviews, observations, and document reviews that significant progress had been made toward compliance since the baseline review. The Nursing Department's Presentation Book was comprehensive and thorough in describing improvements and achievements accomplished since the baseline review. Since the baseline review the Infection Control Committee workgroup had reviewed and revised all Infection Control Policies and Procedures as was evidenced through review of the Infection Control Manual. The Infection Control Department had a Pandemic Respiratory Infectious Disease Readiness Plan to use in case of influenza outbreak. Since the baseline review the Infection Control Department worked collaboratively with the Data Analyst and had developed and begun implementing a revised and improved Infection Control Access Database. The database was more comprehensive than the previous database that was in an Excel program which was limited in it's capability to link clinical data. The Infection Control Officers demonstrated the database for the	N

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		monitoring team. It was most impressive and could serve as a good model for the other State Facilities. The purpose of this improved database system was to collect meaningful and valid data that can be utilized to trend over a designated date range as well as to quickly assist clinical staff in identifying emerging infectious issues so that the Facility staff can address them expeditiously. The data elements are collected and tracked from three sources: Individual Infection Control Forms, Pharmacy notifications, and State Lab Reports. These three data sources were used to validate the integrity of the Infection Control data. The database was based on infection type episodes (onset and resolved dates) for an individual. An individual can have multiple episodes with corresponding infection types, e.g., upper respiratory infections, soft tissue boils/abscesses. Within any given episode, multiple medications can be captured as well as x-rays, cultures, and other diagnostics. Having the ability to link clinical data will be useful in making clinical decisions for the individual as well as identifying systemic trends. Information from the Infection Control database can be used by clinical disciplines as well as other disciplines in making decisions regarding care, for example: • Nurse Case Managers, Unit Nurse Managers, and nurses (homes and Infirmary) can utilize the reports to determine if any infectious issues were emerging as well as to assist with individual care planning, and nursing assessments. • Medical staff can also use the application for individuals/homes/units trends and infection histories as well as accessing antibiogram data after the future phase enhancement. • Habilitation clinical staff, Physical therapist, Occupational Therapist, and Speech Language Pathologist, can utilize the database, primarily regarding pneumonia information to identify high risk individuals to be closely monitored by the Nutritional Management Team with proactive PNMPs. • Unit Director and Upper Administrative staff can utilize the database to identify general campus wide trends that may require corrective action. Many of reports were currently available and can be generated based upon date range. The primary report classifications that can be generated include: • Report by Individual • Report by Home • Report by Types of Infection and Category (details, trend reports, and x-rays, cultures, and other diagnostic) o Types of infections included: ▪ Gastroenteritis ▪ Lower Respiratory	

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		▪ Upper Respiratory ▪ Ophthalmic and Otic ▪ Pneumonia ▪ Soft Tissue ▪ Urinary Tract ▪ Reproductive Tract ▪ Sepsis/Unexplained Febrile Episode ▪ Organisms Identified, e.g., MRSA. MDRO, and VRE as were as other commonly identified organisms The Infection Control Department was planning future applications and enhancements for the database to include antibiogram implementation. The Infection Control Department would like to be able to have the capacity to import the State lab antibiograms directly into the database as opposed to receiving a paper copy from the State lab and entering the data manually into the database. The ability to import the State antibiograms would be time saving and make such data readily available and accessible to physicians. Antibiograms were published monthly by the State lab and were used by Facility physicians to identify which antibiotics specific organisms are sensitive to and aid them in prescribing appropriate antibiotic therapy for various types of infections. Additional reports can be sorted on other existing data elements, e.g., influenza reports by home, unit, and campus wide as well as other infectious data on aspiration pneumonia, hospital and community acquired pneumonia, viral pneumonia and other infectious diseases. The projected date for full implementation of the database was January 1, 2011. According to the Infection Control Officers, the database needs to be totally populated and other modifications and applications need to be made to the database. However, the two Infection Control Officers do not have time to complete these tasks and keep up with the other Infection Control issues for which they are responsible for managing. This was discussed with the Facility Director during review who agreed to provide the Infection Control Department with a Data Entry Clerk to populate the database and free up the Infection Control Officers to make the modifications to the database and fulfill their other obligations. In order to ensure proper reporting and follow-up on all individuals with infections and to ensure reliability of data received, a Reporting and Follow-up Procedure for all Individuals with Infections Policy was drafted on 10/25/10. Procedures included: • Reporting Procedure: o After sick call, nurses will fill out an Individual Infection Control Form and fax/e-mail the Form to the Infection Control Office.	

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		o A copy of all Acute Care Plans for infections will be forwarded to the Infection Control Office for review. o Pharmacy will e-mail the Infection Control Office daily of all newly prescribed antibiotics ordered and filled by the Pharmacy. o Lab personnel will drop off all cultures and urine analysis reports daily as received to the Infection Control Office. o Radiology personnel will deliver all in-house chest x-rays to the Infection Control Office every Monday. • Tracking, Trending, and Analysis: o The above information will be entered into the Infection Control Database on the share drive. Data will be checked for any trends and analyzed for in-service education opportunities. • Follow-up: o The Infection Control Officers will provide in-service education to direct care professionals and nursing staff by type of infection or identified trends when deemed necessary. o When an individual diagnosed with an infection is seen by the physician and the infection determined resolved, the nursing staff will complete an Individual Infection Control Form stating the infection was resolved and send the Form to the Infection Control Office. The information will be entered into the Infection Control database. o When the Infection Control Database becomes fully operational the acute Care Plan initiation and resolution data will be added. As the Infection Control Database becomes fully operational the Infection Control Department should be able to produce reliable data for which trend analyses can be performed on types of infections, by individual, home, unit, and campus wide. This should assist the Infection Control Department toward substantial compliance with this provision of the Settlement Agreement. The Communicable Diseases by Select Code Reports for reportable infections for the reporting period since the baseline review, 4/1/01 through 8/31/10, were reviewed. The tracking data captured date of diagnoses, antibiotic therapy received, date of resolution, and Infection Control Department notes. The report included the type and number of reportable communicable diseases: Records reviewed for individual #217demonstrated follow-up management of communicable diseases: • Individual #217 was diagnosed with Allergic Conjunctivitis on 7/5/10. There was documentation as to when the staff notified the nurse on 7/5/10 at 5:30 p.m., the nurse assessed individual #217's eyes and found the right eye with erythema to the sclera with yellow excudate, a completed assessment including	

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		vital signs was performed and the on-call physician was notified at 6:30 p.m. of findings. On 7/5/10 at 1925 the physician came to the home and examined individual #217 and made the diagnosis of allergic Conjunctivitis. Naphcon A Opthalmatic, one drop four times a day was ordered. Individual was seen in sick call on 7/6/10. On 7/6/10 the Integrated Progress Notes indicated that a Conjunctivitis Acute Care Plan was initiated and direct care staff were instructed. Review of the Training Roster validated the fact staff were trained on all three shifts. The Conjunctivitis Acute Care Plan was adapted from the Health Care Protocol for Developmental Nurses. The plan was appropriately individualized to meet individual#217's needs. Review of the Integrated Progress Notes, 7/6/10 through 10/15/10, contained documentation that individual #217 was monitored at least daily until the problem was resolved on 10/15/10. Since the baseline review the Infection Control Officers had begun completing an analysis of Pneumonia from Infection Control tracking data. This was a positive finding. The Infection Control Officers reported a pneumonia trend analysis report as follows: In the 4th Quarter (June, July, and August, 2010), a total of six cases of pneumonia were reported. Five of the six (83%) were diagnosed with aspiration pneumonias with one of the six (16%) diagnosed with viral pneumonia. All six of the individuals diagnosed with pneumonia were hospitalized. Two of the six (33%) expired during hospitalization. Three of the six individuals (50%) were diagnosed after being hospitalized for at least one week with one individual being hospitalized over a month before being diagnosed with aspiration pneumonia. The three individuals diagnosed after hospitalization were admitted for other reasons, e.g., dehydration and chronic bronchitis. Two of the five cases (40%) diagnosed with aspiration pneumonia resided on the medically fragile unit (Trinity). One individual diagnosed with viral pneumonia resided in the Rivers Unit. This was a good start in analyzing and trending pneumonia data. The Infection Control Department needs to take the pneumonia analysis further to identify potential contributing factors causing the pneumonias and develop a plan of prevention based on findings. For example, they might review aspiration pneumonia that occurs following several days of hospital stay and establish an improvement plan to minimize that. Review of Infection Control data on the infection report, 9/1/10 through 10/25/10, revealed 10 cases of pneumonias of all types. Types of pneumonia and home of individuals diagnosed are listed below: • Pneumonias by Type: o Of the 10 cases pneumonia, three or 30% were aspiration pneumonias o Of the 10 cases pneumonia, four or 40% were viral pneumonias o Of the 10 cases pneumonia, two or 20% were bacterial pneumonias	

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		o Of the 10 cases pneumonia, one or 10% was hospital/community acquired pneumonia • Pneumonia by Home: o Of the 10 cases of pneumonia, four cases of pneumonia or 40% were diagnosed in individuals residing in San Antonio ▪ 2 bacterial pneumonias ▪ 2 viral pneumonias o Of the 10 cases pneumonia, three cases of pneumonia or 30% were diagnosed in individuals residing in Trinity ▪ 1 aspiration pneumonia ▪ 1 viral pneumonia ▪ 1 hospital community acquired pneumonia o Of the 10 cases pneumonia, two case of pneumonia or 20% were diagnosed in individuals residing in Neches ▪ 2 aspiration pneumonias o Of the 10 cases pneumonia, one case of pneumonia or 10% was diagnosed in an individual residing in Four Rivers. ▪ 2 viral pneumonia As the Infection Control begins to track and trend incidents of pneumonia by type, individual, and place of residents, the Infection Control Officers need to analyze causative factors contributing to the pneumonias and take remedial action to prevent or minimize their reoccurrence. Review of the Infection Control Committee Meeting Minutes, 6/29/10 and 9/21/10 revealed that the Infection Control Committee met quarterly. Minutes reflected review and discussion of the quarter's infections. Infections reported for 3rd and 4th quarter are listed below: • Third Quarter (March, April, and May, 2010) o MRSA – 5 o Pneumonia – (one being aspiration) o Upper Respiratory Infections – 14 o Lower Respiratory – 5 o Gastrointestinal – 2 o Conjunctivitis – 11 • Fourth Quarter (June, July, and August, 2010) o MRSA – 6 o Urinary Tract Infection – 9 o Upper Respiratory – 1 (exacerbation of chronic bronchitis) o Gastrointestinal – 5 o Conjunctivitis - 9	

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		Both Infection Control Committee Meeting Minutes reported that the various infections were spread throughout the campus with no evidence of clustering. Even when there was no clustering of infections identified in review of infections, the Infection Control Committee needs to explore causative factors contributing to individual infections in order to prevent or minimize their occurrence. The Infection Control Committee Meeting Minutes reflected discussion and problem solving measures regarding a variety of environmental issues, such as problems with inappropriate items found in the laundry that could cause hazards to laundry staff and damage the washing machine. The Infection Controls Officers took pictures of item found in the laundry and attached them to e-mails sent Unit Directors and/or supervisors to ensure that the staff did not place hazardous material in the laundry. Environmental Surveillance continued to monitor the laundry situation monthly. A concern identified by monitoring team during a tour of Trinity was numerous brown stained ceiling tiles observed throughout the building probably caused by a leaking roof and/or condensation. According to the Infection Control Officer the building's roof was scheduled for repair within the next seven months. The brown stained tiles were potentially growing mold. Trinity houses the most medically fragile and complex who are potentially at risk for infections, particularly respiratory and/or pneumonias. What appeared to be black mold spores were seen on the ceiling tiles at the entrance of the Administrative Building. Mold spores growing on ceiling tiles can become airborne. According to the Center of Communicable Diseases (CDC) prolonged exposure to mold spores can have potentially negative health effects, such as allergic reactions, respiratory problems (wheezing and asthma), nasal and sinus congestion, watery, red or burning eyes, dry, hacking cough, sore throat, shortness of breath, skin irritation, central nervous system problems (headaches, memory problems, mood swings), aches and pain, and possible fever. The Facility should expedite the repair of the roofs, replace damaged ceiling tiles, and provide abatement of mold according to Environmental Protection Agency Guidelines in Trinity and the Administration Building soon as possible. Review of Infection Control Monitoring Forms (4th Quarter FY2010 (June, July, and August, 2010) and Report indicated that the Infection Control Office completed random Environmental Surveillance monitoring. The Nurse Case Managers and other home staff assisted with monitoring. All completed monitoring forms were forwarded to the Infection Control Office for evaluation. Review of the completed monitoring forms for the 4th Quarter FY 2010 revealed that 41 staff had been observed for hand washing and standard precautions. Observations were conducted on all three shifts and on each unit. On the spot training was completed for staff who were observed failing to follow proper handwashing techniques and/or to correctly follow standard precautions. There was evidence that when Environmental Surveillance problems were identified they were	

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		either corrected on the spot or the appropriate supervisor(s) were notified of the problems and instructed to correct the problems. RSSLC's Competency Development and Training (CDT) Course Delinquency List, 10/26/10, indicated that 10 employees were delinquent in the required Infection Control training. CDT routinely sent employees' supervisors a due list of employees who were delinquent in training. The CDT Director and delinquent employees' supervisors need to ensure employees who are delinquent in Infection Control training are brought up to date as soon as possible. The Infection Control Officers' areas of responsibilities were broader than nursing. The Infection Control Officers participated in activities that were integrated into all services of the Facility. Areas of responsibility included: • Meetings: Nutritional Management Team, Construction on Campus, Skin Integrity, all Nursing Meetings, and Pharmacy and Therapeutics. • Working collaboratively with Laundry Department, Safety Officer, Risk Management, Central Kitchen, Habilitation Department, Maintenance Department, Forever Young Stables, Housekeeping Department, Residential Directors, Unit Directors, Pharmacy Department, Quality Assurance Department, and Director of Support Services, Competency Development and Training Department, Physicians, Laboratory Department, Radiology Department and Direct Care Staff. • The Infection Control Officers dealt with any issues that involved infection or safety. Because of the broad area of responsibility the Infection Control Officer constitutes a departmental level within the organization. The Skin Integrity/Wound Care Committee continued to meet weekly. The Committee was chaired by the Skin Integrity Coordinator. Committee participants were comprised of interdisciplinary representatives who included but were not limited to: Chief Nurse Executive, Nurse Case Managers, Hospital Liaison Nurse, Infection Control Officers, Dietitian, Quality Assurance Nurses, Medical Director, Pharmacist, and Habilitation. Review of the Skin Integrity Committee Meeting Minutes, 4/1/10 through 10/27/10, demonstrated active participation by the Committee representatives in reviewing, discussing, problem solving, and revising skin integrity plans, when indicated, related to individuals with pressure ulcers and/or other skin integrity issues. The Nurse Case Managers brought copies of Acute Care Plans (ACP) and/or Health Management Plans (HMPs) to the meeting for individuals discussed. When the care plans required revision they were made at the time of the meeting.	

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		Monitoring team attended the Skin Integrity Committee Meeting on 10/27/10. The observation of the meeting confirmed the function of the Committee as was reflected in review of the Committee Minutes. The Committee reviewed and discussed the management of care of individuals with pressure sores and/or other skin integrity issues from 10/20/10 through 10/27/10. Individual #7 was reported to have an unstageable pressure sore on the left lateral foot, sized at 0.4 centimeters (cm) by 0.3 cm by 0 cm that was hospital acquired on 9/7/10 and a stage two pressure sore on the left inner ankle, sized at 0.5 cm by 0.4 cm by less than 0.1 cm, facility acquired on 10/20/10. Heel protectors had been ordered to use at all times. The direct care professionals had been in-serviced on their use with in-service sheets signed and documentation in the Integrated Progress Notes. The Dietitian stated she would add Bene Protein to diet to promote healing. Individuals with non-pressure sores were also reviewed and discussed. They included individuals #212, #320, #267, #665, and #415. Nurse Case Managers brought health care plans to the Committee meeting. For example, the Nurse Case Manager brought to meeting the ACP for individual #415's Post Operative Sebaceous Cyst Incision and Drainage, 10/3/10. The ACP was developed using the newly implemented Health Care Protocol for Developmental Nurses. It was positive to find that the ACP was individualized to meet this individual's unique health care needs. The direct care professionals were instructed in their areas of responsibly for caring for the wound. It was reported that mattresses for non-ambulatory individuals who needed new mattresses had been replaced with air flow mattresses. The Committee failed to discuss systemic measures to prevent skin breakdown. The Skin Integrity Committee needs to continuously explore systemic measure to prevent or minimize skin breakdown. Review of the Decubitus Report, FY 2010 (3rd and 4th quarters), indicated that pressure ulcers were reported and tracked on a monthly basis and summarized quarterly. Since the baseline review the report indicated the following number and dispensation of pressure ulcers: • Third Quarter Reported: o Seven individuals were diagnosed with pressure ulcers. o Two pressure ulcers were acquired in the hospital. o Eleven pressure ulcers were acquired outside (hospital/long term facilities). o Three stage one pressure ulcers – a persistent area of skin redness (without break in the skin) that does not disappear when pressure is relieved. o Five stage two pressure ulcers – a partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater. o Five unstageable pressure ulcers – full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed. o Thirteen suspected deep tissue injuries – purple or maroon localized area of discolored intact skin or blood blister due to damage to underlying soft	

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		tissue from pressure and/or shear. Area may be preceded by tissue that is painful, firm, mushy, warmer or cooler than adjacent tissue. • Fourth Quarter – there were no reported pressure ulcers reported. These reports indicated improvement since the baseline review where pressure ulcers were reported each quarter. However, the Skin Integrity Committee, as mentioned above, needs to continuously explore systemic measures to prevent or minimize skin breakdown.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Facility was not in compliance with this provision. . Even though the Nursing Department had not achieved substantial compliance with this provision it was evident through interviews, observations, and document reviews that significant progress had been made toward compliance since the baseline review. The Nursing Department's Presentation Book was comprehensive and thorough in describing improvements and achievements accomplished since the baseline review. Since the baseline review the Nursing Department had enhanced and/or implemented new monitoring practices for monitoring Medication Administration. They included: • Medication Administration Observations for oral medication and enteral administration were completed monthly on nurses administering medications. When nurses failed to follow correct Medication Administration procedures, they were corrected and counseled on the spot. If the severity of the failed practice was significant, the nurses were not allowed to administer medication independently and were observed passing medications until they were deemed competent to pass medications independently. When indicated the nurses were given disciplinary action and/or were sent to the Nurse Educator for additional training. • Medication Room Compliance Observations were completed monthly, at the time of the Medication Observations. • Medication Administration Records Audits were completed and co-signed daily by two nurses, from off-going and on-coming shifts, to prevent medication errors. • Nursing staff completed 24 hours chart check to ensure that all Physician Order's were transcribed and were accurate with follow-through as indicated by the orders. • Sedation/Pre-sedation Logs were maintained monthly. The logs included individuals name, date, type of sedation, whether consents were signed, and whether there was Human Right Committee approval. According to the Chief Nurse Executive the Medication Administration Observations and medication errors were analyzed and summarized in the Medication Error Committee	N

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		Meetings. Review of the above information, supplied through the document request, verified that these monitoring and/or audits were completed as described. It was evident from the review when deficiencies were identified that corrective action was taken as was validated through documentation contained on the completed Medication Administration Observations and Medication Room Compliance Forms. Review of the daily Medication Administration Record Audits found them completed daily on each shift with rare exception. The Medication Error Committee continued to meet monthly. The Committee was chaired by the Chief Nurse Executive. Committee participants were comprised of interdisciplinary representatives who included but were not limited to: Nurse Managers, Campus Nurses, Nurse Case Managers, Hospital Liaison Nurse, Infection Control Officers, Quality Assurance Nurses, Medical Director, Pharmacist, and Unit Directors. Review of the Medication Error Committee Meeting Minutes indicated that all medication errors occurring within the past month and the corrective action taken to continue to prevent and/or reduce the occurrence were discussed for each unit reporting medication errors. Relevant information derived for the monthly Medication Administration Observations was discussed and when indicated corrective action recommendations were made. The Committee meeting also serves as an opportunity for updates from other disciplines, e.g., Pharmacist, Dentist, and Medical Director, as well as a forum for continuing education. The monitoring team attended the Medication Error Committee Meeting on 10/28/10. The Chief Nurse Executive reported that three medication errors were reported for the past month (September, 2010), two in Leon and one in San Antonio. The medication error in San Antonio resulted in an omission due to the physician writing the order in the Psych Clinic and the order was misfiled and did not reach the RNII to transcribe the order. The medication error was caught and corrected. The two medication errors that occurred in Leon were due to the failure of the medication order not to carry over from the previous month to the new Medication Administration Record. The monitoring team expressed that the failure to carry over medication orders prescribed near the end of the month and hand written on the existing Medication Administration Record was a common problem occurring in other Facilities. When asked if this was a common problem at RSSLC, the Pharmacist stated that the Pharmacy was addressing this issue and it did not seem to be a significant problem at RSSLC. The monitoring team reviewed concerns indentified regarding the Medication Administration Observation completed earlier in the day. Issues of concern included: The use of plastic picnic style spoons as opposed to using maroon or mother care spoons. Poor positioning during administration of medications. Identification of expired medications and solutions in the	

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		refrigerator in San Antonio C. The CNE stated that maroon spoons had been ordered for all units and should be in use. She will follow-up on the use of maroon spoons and the other concerns identified. The Pharmacy and Therapeutics Committee continued to meet quarterly. The Committee was chaired by the Pharmacy Director. Committee participants were comprised of, but not limited to Physicians, Advanced Practice Registered Nurse, Chief Nurse Executive, Nurse Managers, and Infection Control Officer. Review of the Pharmacy and Therapeutic Committee Meeting Minutes for 3/30/10 and 7/13/10 included a report of monthly medication errors. There was no further discussion regarding medication errors. Even though the number of medication errors did not appear to be significantly high, the Pharmacy and Therapeutics Committee needs to explore all causative factors contributing to medication errors, particularly if they were related to dispensing errors by the Pharmacy or prescribing errors committed by the physicians and/or Advanced Practice Registered Nurse. The nursing staff are not the only discipline who have the potential to commit medication errors. The monitoring team's review of available medication error data reflected only medication errors committed by the nursing staff. The Pharmacy and Therapeutics Committee and Medication Error Committee needs to evaluate and revise their Medication Error Policy and expand it to include all medication variances. Reported Medication Errors, April, May, June, July, and August, 2010 (no data available for review for September and October, 2010): • April 2010 total errors – 17 o Extra dose – 13 o Wrong time – 1 o Wrong time – 1 o Wrong route – 1 o Wrong drug – 1 • May 2010 - total errors – 10 o Extra doses- 3 o Omissions – 7 • June 2010 total 8 o Extra doses – 1 o Omission – 1 o Wrong time – 6 • July 2010 – total errors - 13 o Omissions – 13 Since the baseline review it was apparent though observations and review of documents that significant effort had been put forth to decrease the occurrence of medication errors.	

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		Medication errors were reviewed and analyzed during the Medication Error Committees Meetings. Medication error data were represented monthly by line graphs. Medication Error data were reported by type of errors. The Medication Error Report Form contains numerous data elements that could be used to complete a root cause analysis and should be used to analyze factors contributing to medication errors which could be used to make clinical decisions to plan strategies to further prevent or minimize medication errors. The Nursing Department needs to collaborate with the Data Analyst to review the Medication Error Report Form to evaluate the possibility of developing a more comprehensive trend analysis of medication errors. Review of the last 10 medication errors revealed the following findings: • One or 10% of medication errors was classified as Category A, e.g., circumstances or events that have the potential to cause error. • Nine or 90% of medication errors were classified as Category C, e.g., an error occurred that reached the individual but did not cause individual harm. • Eight or 80% of the medication errors related the same incident where two nurses failed to discontinue medications on the Medication Administration Records after the physician had discontinued the medications. The Nursing Department's Procedure for transcribing Physician's Order required that two nurses sign all transcription orders. There was documentation on the Medication Error Forms that the responsible nurses received counseling by their supervisor regarding correct procedure for transcribing orders. • One or 10% of the medication errors was related to an omission. There was documentation on the Medication Error Form that the nurse committing the error was counseled by a supervisor on correct medication administration procedures. • One ore 10% of the medication errors was related to extra doses. There was documentation on the Medication Error Form that the nurse committing the error was counseled by a supervisor on correct medication administration procedures. • Nine or 90% of the medication errors were discovered after two or more days, with a range from two to 13 days later. The Nursing Department's procedure for checking Medication Administration Record required that two nurses, from off-going and on-coming shifts, daily review and co-sign the Medication Administration Record daily in order to prevent medications errors. This practice should have caught the medication errors within the first shift that the errors occurred. It was a concern that eight of the medication errors classified as Category C were not discovered for more than 24 hours. Categories C were errors that reached the individual but did not cause harm. It was difficult to believe how a judgment could be made that the	

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		medication error caused no harm or ill effect after being discovered after more than 24 hours. However, it was positive that the medication errors were discovered and corrective action taken by the supervisor. The Nursing Department needs to continue to strengthen the Medication Administration Record Audits in order to discover quickly medication errors and assess the individuals to ensure that no harm was caused from the medication errors. Medication Administration Observations were completed in San Antonio C, on 10/28/10 at the 12:00 noon medication administration pass. Individuals #619, #27, and #421 were observed receiving medications. The staff nurse administering medications followed all aspects of correct medication administration procedures. The staff nurse was extremely sensitive and courteous to individuals as medications were administered. Privacy was afforded individuals by bringing them into the Aid Station to receive medication. A comfortable chair was provided for individuals to sit in while receiving medications. Each person was addressed by name, told the names of the medications, the purpose of each medication, and to assist with medication administration to the degree possible. Individual #619's helmet was removed before administering medication and replaced after receiving medication. The staff nurse thanked each individual for his or her cooperation after receiving medications. The direct care professionals quietly and efficiently escorted each individual to the Aid Station for medication. The staff nurse reported that individuals' Self Administration of Medication training occurred on the evening shift. The PNMPs were in each individual's Medication Administration Record but did not contain instructions for medication administration or oral care. The staff nurse referred to and followed other relevant PNMP instruction. There was a concern with individual #27's positioning plan. The PNMP stated that individual #27 was independent in positioning. However, individual #27 required a wheelchair, had kyphosis and was leaning forward with head and neck hyperextended when swallowing medication mixed with pudding. Hyperextending the head and neck when swallowing has the potential to cause aspiration. Concern regarding individual #27 was expressed to the staff nurse and Quality Assurance Nurses accompanying monitoring team. The Quality Assurance Nurses will make a referral to the PNMT to evaluate individual #27 during medication administration and the need for prompting or other measures to improve positioning. Only plastic picnic spoons were available on the medication cart to use for administering medications mixed with food stuff. The use of maroon spoons was recommended at the baseline review, particularly for individuals who have an involuntary bite reflex. The Quality Assurance Nurse related maroon spoons had been order and were supposed to be used. She will follow-up on the maroon spoons. The PNMP team needs to include instruction for medication administration and oral care on the PNMPs. PNMPs should also include the texture for the pills and how many pills could be safely administered at any one time.	

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		While touring the Units it was observed that Trinity had received three new medication carts. One of the old medication carts in Trinity B was in very poor repair and needed to be replaced. One of the carts' top surface was covered with a plastic mat that was dirty, with moisture observed under the mat. The moisture has the potential to grow bacteria. The staff nurse was instructed by the Quality Assurance Nurse to clean the top surface of the medication cart, including the mat and to dry the moisture under the mat. The Facility needs to evaluate medication carts that are in poor repair and replace them as soon as possible to ensure that medications are safely stored and locked. The Nursing Department needs to continue to monitor medication carts to ensure they are clean and free from contamination. Medication Administration Records were reviewed in Trinity C. Signature Sheets listing all nursing providing medications were present. Many of the signatures were illegible. Many of the individuals' pictures had not been updated since 2000, e.g., individual #649's picture. The Nursing Department needs to ensure that nurses' signatures are legible. The Nursing Department needs to evaluate individuals' pictures in the Medication Administration Records. Individuals whose pictures were too old to clearly identify the individual should be replaced with a current photograph. The medication box in the refrigerator in San Antonio was checked for expired medications. A vial of tetanus toxoid vaccine was expired as of 9/27/10 and Colyte solution was mixed on 10/25/10. Once Colyte was mixed it was only good for 48 hours. It was expired by a day. The Quality Assurance Nurse instructed the staff nurses to return the expired tetanus toxoid vaccine to Pharmacy and dispose of the Colyte. Narcotic Logs were checked for double signatures of both the off-going and on-coming shift nurses' signatures. Double signatures were missing for Dorm A's Narcotic Log on 10/23/10 on the 2p.m. to 10 p.m. shifts and on 10/24/10 on the 6 a.m. to 2 p.m. shifts. Double signatures were missing from Dorm C's Narcotic Log on 10/24/10 on the 6 a.m. to 2 p.m. shifts. During the tour individuals' # 106, #324, and #454, who were receiving continuous/intermittent enteral nourishment, were observed in the Trinity Activity Room. All individuals were sitting up in their wheelchairs with good positioning. All individuals were engaging in activities with the assistance of staff and appeared comfortable without evidence of distress. The enteral nourishment containers had been changed/hung within 24 hours. Pumps and tubing's were in good working order and clean. This was a positive finding.	

Recommendations:

1. Because of the complex and multifaceted level of professional responsibilities, coupled with large professional nursing staff the Facility may wish to

consider the Chief Nurse Executive's level of designation within the organizational structure.
2. The Nursing Department needs to continually evaluate the need for additional staffing and other resources to meet the increasing needs of individuals served.
3. The Nursing Department needs to develop a Nursing Peer Review Committee that reviews and analyzes audit data derived from the peer reviews in an effort to identify and solve problems in nursing practice as a means to improve the quality of nursing services provided.
4. The Facility needs to standardize the method for which time is documented in the Integrated Progress Notes and other documents to ensure continuity and to avoid confusion.
5. The Nursing Department needs to consistently use one term for continuity, preferably "individual, " when referring to Facility residents.
6. The Nursing Department needs to ensure that nurses use sensitive and professional terminology when documenting in individuals' records.
7. The Nursing Department needs to ensure that nurses write in third person.
8. The Nursing Department needs to ensure that Nurse Case Managers do not combine several risk factors and/or nursing diagnoses together into one nursing diagnosis as well as combine them into one HMP.
9. The Nursing Department needs to ensure that there is a nursing diagnosis and HMP for all medium and high health risk levels as well as for other chronic health conditions that are listed as active medical problems.
10. The Nursing Department needs to continue to reinforce training on the Comprehensive Nursing Assessment. The Nurse Case Managers need additional training in analyzing and summarizing clinical data related to individuals' health status as identified in nursing diagnoses.
11. The Nursing Department needs to continue providing nurses with training on the use of the Health Care Protocol for Developmental Disability Nurses to ensure that the protocols only serve as a guide for developing nursing care plans and should never be used wholesale without exercising their professional judgment to individualize the plans to meet the individuals' unique needs.
12. The Facility Director needs to ensure that there is harmonious working relationship between the residential staff and nursing staff.
13. The Nursing Department needs to continue to monitor documentation and take corrective action to ensure that Integrated Progress Notes are written chronologically.
14. The Nursing Department needs to cease the practice of only training the Unit Specialists and Residential Coordinators on the HMPs and ACPs and assign the nursing staff on each shift the full responsibility for training direct care professional staff on HMPs and ACPs.
15. The Nursing Department needs to ensure that when individuals have complaints of pain or discomfort that a thorough nursing assessment is completed by the RN and the physician promptly notified of the findings. The physician should make the judgment call as to whether the individual needs to be seen immediately or can wait to be seen in sick call the following day.
16. Even when there was no clustering of infections identified in review of infections, the Infection Control Committee needs to explore causative factors contributing to individual infections in order to prevent or minimize their occurrence.
17. As the Infection Control begins to track and trend incidents of pneumonia by type, individual, and place of residents, the Infection Control Officers need to analyze causative factors contributing to the pneumonias and take remedial action to prevent or minimize their reoccurrence.
18. The Facility should expedite the repair of the roofs, replace damaged ceiling tiles, and provide abatement of mold according to Environmental Protection Agency Guidelines in Trinity and the Administration Building soon as possible.
19. The CDT Director and delinquent employees' supervisors need to ensure employees who are delinquent in Infection Control training are brought up to date as soon as possible.
20. The Skin Integrity Committee needs to continuously explore systemic measures to prevent or minimize skin breakdown.
21. The Pharmacy and Therapeutic Committee and Medication Error Committee need evaluate and revise their Medication Error Policy to expand it to include all medication variances.
22. The Nursing Department needs to collaborate with the Data Analyst to review the Medication Error Report Form to evaluate the possibility of developing a more comprehensive trend analysis of medication errors.
23. The Nursing Department needs to continue to strengthen the Medication Administration Record Audits in order to discover quickly medication

errors and assess the individuals to ensure that no harm was caused by the medication errors.

24. The PNMP team needs to include instruction for medication administration and oral care on the PNMPs. PNMPs should also include the texture for the pills and how many pills could be safely administered at any one time.
25. The Facility needs to evaluate medication carts that are in poor repair and replace them as soon as possible to ensure that medications are safely stored and locked. The Nursing Department needs to continue to monitor medication carts to ensure they are clean and free from contamination.
26. The Nursing Department needs to evaluate individuals' pictures in the Medication Administration Records. Individuals whose pictures were too old to clearly identify the individual should be replaced with a current photograph.

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:** 1. Richmond Plan of Improvement (POI) 5/17/10 2. Richmond Supplemental Plan of Improvement (SPOI) 7/5/10 3. Clinical records, including PSP, progress notes, annual physical exams, all diagnostics, MOSES, DISCUS assessments, quarterly drug review for individuals #619, #296, #503, #542, #470, #6, #465, #146, 564, #442, #574, #150, #99, #249, #644, #174, #765, #662, #584, #25, #791, #649, #252, #530 and #745 4. Adverse Drug Reaction Form 5. P&T minutes, August, 2010 **People Interviewed:** 1. Anto Parambil, R.Ph. 2. Michael Shatz, Pharm.D. **Meeting Attended/Observations:** 1. Morning Physician Meeting, October 27, 2010 2. Face-to-Face observation of individuals #770, #140, #547 3. Observed pharmacy operations, November 28, 2010
	Facility Self-Assessment: The Facility reported that it is not compliant with any Action Step of Section N of the SA. The Pharmacy Department has begun some important steps that if continued, will help to lead the Facility in the direction of compliance with the settlement agreement. First and foremost is the quality of pharmacy reviews for cases identified as a concern and also the participation of the Clinical Pharmacist at physician meetings and psychiatric consultations. The monitoring team confirmed participation by the pharmacist in those meetings as reported in the facility self-assessment. Staff pharmacists review all new medications orders according to the medication order review policy to validate for medication, dosage, frequency, duration and indication. They use WORx to input new orders. WORXx program has the capability of checking sensitivities and interactions. Staff pharmacist manually checks the dosage and indication while processing the new order. Nevertheless, there were many failures of this system to identify, document, and respond to issues that should be addressed, such as medications dispensed outside pharmacy hours, omissions in information on scripts, and medications dispensed after the pharmacist identified allergies or drug interactions and without further evaluation. In general, the Facility understood that it has made minimal progress in addressing pharmacy issues related to the Settlement Agreement.
	Summary of Monitor's Assessment: The review team noted the high quality of professionalism offered by the clinical pharmacist at the Facility

	and has determined that the Facility is in substantial compliance with Provision N2; however, additional benefit to individuals served and potentials for significant saving on enhanced drug utilization could be achieved by increasing the number of clinical pharmacists and strengthening the pharmacy review process. The Facility had made no progress in the areas of utilization review, drug variances, and monitoring for Metabolic Syndrome. Importantly, physicians accounted for significant prescribing variances that have the potential for serious adverse outcome and pharmacists. Pharmacy related committees such as P&T and the Nursing Medication Error Committee must be evaluated and restructured to be more efficient and efficacious. The Facility had no database system specific for pharmacy applications such as drug variances, utilization review and adverse drug reactions. Given the findings, the monitoring team concludes that the Facility was not in substantial compliance with Sections N1, N3, N4, N5, N6, N7 and N8.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The monitoring team had an opportunity to observe the processing of medication orders and dispensing of drugs at the Facility and to discuss issues related to the processing of medication orders with the Facilities Director of Pharmacy. Each order that is processed by the pharmacy is reviewed by a pharmacist prior to dispensing of the medication. Once received, the pharmacist is supposed to review all orders for accuracy, completeness and appropriateness. Issues such as diagnosis or indication, date, time, allergies, contraindication, drug-drug and food drug reaction, need for diagnostic studies and compliance with the State Formulary, are to be reviewed by the pharmacist prior to dispensing of the medication. In the event of a variance, the pharmacist is expected to complete a Pharmacy Intervention Report, contact the prescribing physician and reconcile differences. During the review of pharmacy services the process was noted to have failures: • Along with the Director of Pharmacy, upon review of completed orders it was noted that allergies were not consistently documented on the physician order form, which is required by the Facility. • As described by the Director of Pharmacy, during after hours, when medication were not dispensed by the pharmacy staff, and were instead obtained by the nurse from "convenience boxes, " there had been instances when medications were administered to persons who have allergies to those medications. • As observed along with the Director of Pharmacy, there existed examples of scripts being completed with omissions, such as time and indication, without the pharmacist following protocol and completing a Pharmacy Intervention Report.	N

#	Provision	Assessment of Status	Compliance
		• During the review of dispensing practices, along with the Director of Clinical Pharmacy, medications had been dispensed without the appropriate diagnosis, hence, off label use per the FDA, and the pharmacist did complete a Pharmacy Intervention Report. • As described by the Director of Pharmacy, there was no mechanism in place for pharmacists to ensure that necessary diagnostics, such as laboratory studies and EKGs, had been ordered when completing either new orders or when adjusting doses of a medication that requires diagnostic monitoring. The order must be forwarded to the Clinical Pharmacist for review at a later time. • When significant interactions or allergies were listed in the clinical record, there were examples of medications being dispensed and administered without further evaluation or enhanced monitoring, even after concerns were raised to the prescribing physician by the dispensing pharmacist. In general, the dispensing pharmacist will complete a Pharmacy Intervention Report and document a discussion with the physician and dispense the medication without involving clinical leadership. • Physicians were noted to prescribe medications that were already ordered. Examples of inaccurate prescribing include: • Individual #150, antibiotic prescribe when documented allergy. In this case the individual received the same antibiotic in 2008 by error; however, no reaction was noted and the allergy list was not updated to reflect no allergy, so the medication was continued. • Individual #99, prescription for Vimpat and on review by the pharmacist noted that it was a subtherapeutic dose and the dose had to be changed from 25 mg to 50 mg bid. • Individual #249 was prescribed Keflex with known Penicillin allergy and the order was changed to Bactrim. • Individual #644 was prescribed Vimpat 50 mg in the am and 100 mg in the pm; however, the individual was already on 100 mg twice a day. The physician revised the order to reflect the previous dose. • Individual #174 was reviewed by HRC for administration of Lithium and a prescription was written. Upon review by the pharmacist it was noted that the individual had an allergy listed for Lithium. • Individual #765 was prescribed amoxicillin by the Dentist; however, the pharmacist noted that the individual had an allergy alert for penicillin so the medication had to be changed to Cleocin. • Individual #662 was prescribed erythromycin eye ointment; however, the pharmacist noted an allergy alert to erythromycin and the order was changed to tobramycin.	

#	Provision	Assessment of Status	Compliance
		• Individual #584 was receiving Clozaril (weekly order) and necessary labs were not done and the order expired. The pharmacist prescribed daily dose of medication until the appropriate laboratory test was orders. This particular drug requires very strict monitoring of the individuals white blood count. Life threatening adverse reactions can occur with this medication secondary to suppression of white blood cells. • Individual #25 was prescribed Claritin for "itching"; however, the pharmacist noted that the individual was already on Claritin so the order was changed to Atarax. • Individual #791 was prescribed Adacel (TDap); however, the pharmacist noted that there was an allergy alert to Tetanus Toxoid so the order was discontinued. • Individual #649 was prescribed prednisone; however, the pharmacist noted that there was an allergy alert to hydrocortisone. The pharmacist contacted the physician who indicated that it was "ok" to give the medication. There was no documentation of extra precautions prescribed to monitor for possible allergic reaction and the allergy list was not updated. • Individual #252 was prescribed Hepatitis A immunization; however, the pharmacist noted an allergy alert to Hepatitis A vaccine, and the order was then discontinued by the physician. • Individual #530 was prescribed Pepto Bismol for diarrhea, without a stop date, hence the order would have continued long-term. The pharmacist clarified the order with the pharmacist and the order was changed to two days. • Individual #745 was prescribed Pneumococcal vaccine; however, the pharmacist noted that the medication had already been prescribed and dispensed the previous year and was not needed. The physician discontinued the order and the medication was not administered.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	The Facility reviewed abnormal and subtherapeutic laboratory values on a quarterly basis, through pharmacy reviews by the clinical pharmacists. All records reviewed (#150, #99, #249, #644, #174, #765, #662, #584, #25, #791, #649, #252, #530 and #745) indicated that the laboratory values were noted by the clinical pharmacist at the time of his review, hence, the Facility is in substantial compliance with Provision N2. Importantly, however, there was no mechanism that served as a stop-gap for abnormal laboratory values that have been missed by the physician, prior to the quarterly review.	SC
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist	Compliance with Provision N3 was discussed in detail with the Facility's Director of Pharmacy. With regards to STAT medications, during the third quarter period, there were eight STAT medications prescribed, dispensed and administered, without any variance noted upon review at a subsequent Quarterly P&T review. The Director of Pharmacy informed the monitoring team that the Facility did not have a meaningful	N

#	Provision	Assessment of Status	Compliance
	shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	mechanism that tracks data related to the use of STAT medications. There was no structured mechanism in place at the Facility to monitor for Metabolic Syndrome. Some elements of Metabolic Syndrome (blood pressure, blood glucose level, and weight) were assessed by the clinical pharmacist during the quarterly reviews; however, there was no specific policy in place or standardized means of what to monitor, frequency of monitoring, and action taken for signs of Metabolic Syndrome. There was no specific policy or standardized process in place to evaluate and monitor the use of benzodiazepines, anticholinergics, and polypharmacy. The Clinical pharmacist attempted to attend all psychiatric consultations and to address such issues; however, since the hiring of additional psychiatrists, his participation at such meetings will be limited and either the redistribution of staff, adding staff or arranging an alternate schedule for pharmacy attendance at psychiatric reviews will be necessary. Importantly, all psychiatric recommendations should be reviewed at some point by a clinical pharmacist. Some issues related to the use of benzodiazepines, anticholinergics, and polypharmacy were addressed at the quarterly P&T meetings, but the P&T Committee did not perform a comprehensive review, collect on-going data, nor perform trends analysis of such use at the Facility. The Director of Pharmacy Services identified deficiencies in this area and the need to develop a specific system to better monitor the use of these medications. In general, the Facility had not developed protocols to address N3 and according to the Director of Pharmacy, they are awaiting the development of a "central policy" and further direction from the Central Office.	
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.	During the review, the Director of Pharmacy was informed the monitoring team that the Facility was not in substantial compliance with N4. The Facility did not have a mechanism in place to ensure physician documentation of pharmacists' recommendations not followed by the physician, nor could examples of documentation of the physicians' clinical rational for not following pharmacists' recommendations be provided to the monitoring team. During discussions with the Director of Pharmacy, the monitoring team was informed that, in most cases, physicians follow the recommendations of the pharmacists or provide a viable explanation to the pharmacist why their recommendation would not be followed. On the rare occasion that the pharmacist does not concur with the physician's clinical rationale the pharmacist will document what the physician said and dispense the medication without further review. The review team expressed considerable concern	N

#	Provision	Assessment of Status	Compliance
		over this practice and explained to the Director of Pharmacy Services that the Pharmacist must raise such issues with clinical leadership to pursue further review.	
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.	To assess compliance with N6, the monitoring team conducted a review of 14 clinical records (#619, #296, #503, #542, #470, #6, #465, #146, 564, #442, #574#770, #140, #547) and three face-to-face observations of individuals (#770, #140, #547). In all cases, the MOSES and DISCUS documentation was noted to be in the clinical record timely. Of the 14 records reviewed, seven were noted not appropriately completed by the clinician, as they did not have the physician's review component of the assessment completed. Of the three face-to-face observations, the monitoring team noted a discrepancy on the monitoring form for one individual, when compared to the findings of the observation. Individual#770 was noted to have a mild ataxic gait and tremor of the upper extremity, and the MOSES and DISCUS dated 6/29 and 9/7 indicated no tremor or gait issues. Most important, the monitoring team noted that despite documented signs of adverse reactions on the DISCUS and MOSES forms, when abnormalities were noted there was lack of a comprehensive evaluation and in no instance was enhanced side effect monitoring recommended. Importantly, physicians had no formal competency based training or re-training on rating instruments used at the Facility.	N
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 Facility utilized an Adverse Drug Reaction Form (ADF) whenever an adverse drug reaction was identified. As reported by the Director of Pharmacy, during the previous six months prior to the monitoring team's visit, the monitoring team was made aware of two adverse drug reactions reported by staff at the living areas, including nurses and physicians (for Individuals #770 and #154). The ADF can be initiated by any clinical staff at the Facility. The completed form is sent to the pharmacy and reviewed by the clinical pharmacist and forwarded to the physician. There is no further documentation required and there is no data tracking or trends analysis of adverse reactions. An ADF was completed on individual #770 for a noted rash on 9/21/10. There was no evidence to support a comprehensive evaluation of the rash and it was considered to be an allergic reaction to soap. The individual was on several medications that may cause a rash, that may develop, resolve and re-appear or manifest in non-rash, systemic adverse reactions.	N

#	Provision	Assessment of Status	Compliance
		Pancytopenia developed following an increase in the dose of Lamictal for Individual #154. The individual was identified and the medication was discontinued, and the individual was seen by a specialist at UTMB, who diagnosed the issues as secondary to medication or viral infection and recommended follow-up with a hematologist. The medication was discontinued and the pancytopenia improved. The clinical pharmacist was most active in review of the case and provided significant information to the clinical team regarding potential drug reaction with Lamictal. It was noted, however, that the Facility did not have an standardized mechanism to address drug reactions and did not maintain appropriate documentation of actions and follow-up to adverse drug reactions. In this case, extensive email communication was filed on the clinical pharmacist's desk. There was no official clinical documentation within the clinical record.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Per discussion with the Director of Pharmacy, with the exception of episodic, ad-hoc review of medications by the clinical pharmacist, an industry standard drug utilization review process does not exist at the Facility. The clinical pharmacist did attempt to provide a utilization review on selected drugs, but there was no on-going, formal process to evaluate the utilization of drugs commonly known to cause side effects, have narrow therapeutic or toxic windows, or to assess efficacy. The Facility did have a Quarterly Drug Regimen Review (QDRR) process to review individuals case by case but not a systemic drug utilization review.	N
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.	Medication variances were not meaningfully addressed by the Facility. Medication variances can fall into four different categories, including storage, dispensing, prescribing and administration variances. The Facility did not have a unified medication variance process to address the types of variances or discipline involved in a variance, such as pharmacy, nursing or physician services. At the time of the review, only medication variances self-reported by nursing staff were reviewed at the quarterly P&T meeting. In June and July, only 21 variances were self-reported. Pharmacy reported no variances and physician services reported no variances during this same period. Given the number of variances in physician prescriptions noted in N1, there should have been corresponding medication variances reported. Pharmacy did not have standard practices in place to monitor for pharmacy-related variances.	N

#	Provision	Assessment of Status	Compliance
		The Facility did conduct a "nursing" medication error committee that addressed nursing variances. The monitoring team did not participate at the committee meeting and was unable to assess its efficacy. Pharmacy and physician services did not participate in a review committee for medication variance. Importantly, there was no mechanism in place to collect data, conduct in-depth analysis or provide appropriate and consistent remedial actions for variances.	

Recommendations:

1. All pharmacists must elevate any issue to the appropriate clinical leadership, in the event they do not agree with the prescribing physician's clinical rationale for not following their recommendation.
2. The Facility must immediately develop a process to closely monitor individuals at risk for Metabolic Syndrome and also those who are on all medications , especially atypical antipsychotics, that can cause Metabolic Syndrome. One mechanism to monitor individuals can be found on-line at http://www.cqaimh.org/pdf/tool_metabolic.pdf
3. The Facility should consult in the Central Office on their progress in developing policies specific to N3 and begin, as soon as possible implementing processes to ensure that STAT medications, benzodiazepines, anticholinergics and polypharmacy are regularly reviewed and that the process includes a trends analysis of their use.
4. For the safety of individuals served, the Facility should consider developing a redundant method to ensure that all necessary diagnostics have been ordered and monitored for abnormal results sooner then every three Months. A modern and certified electronic health care record system, would do this automatically – as soon as diagnostic results were directly downloaded from the laboratory, multiple alerts would notify the clinical staff and clinical leadership of any abnormal values and require immediate action.
5. The clinical pharmacist provides high quality professional insight into many aspects of clinical services. Given his expected responsibilities of providing comprehensive quarterly drug reviews; participating at necessary meetings, such as P&T, psychiatry consultations, and drug variance committee meetings; triaging all questionable medication orders; and following up on adverse drug reactions, there would not be enough time for him to attend appropriately to each activity. Conducting a comprehensive pharmacy review for each of the approximate 396 individual at the Facility would requires at least two hours per individual; hence, 792 work hours per quarter might be necessary just to conduct a quality and meaningful pharmacy review. There are a maximum of 480 work hours per quarter, given no holidays, vacations, sick days or other assignments. It is recommended that the Facility review the organization chart and responsibilities of pharmacy services and if possible restructure and/or allocate additional staff that are qualified to conduct clinical pharmacy. If structured properly, additional clinical pharmacists can offer significant benefit to persons served and substantially impact the Facility's medication budget.
6. The Facility must immediately develop a robust mechanism to address drug variances. A drug variance committee should include all disciplines involved in procuring, storing, dispensing, prescribing and administering medications at the Facility. There should be a single drug variance committee that oversees all drug variances at the Facility and a data base developed to collect data, conduct variance studies and trends analysis. A process should be developed to ensure appropriate action for drug variances and potential drug variances.
7. All commonly prescribed drugs, drugs with narrow therapeutic and toxic windows, all antibiotics and drugs that have potential of commonly causing side effects or cause serious side effects that should be routinely assessed should be included when developing a robust, industry standard drug utilization review process. Data should be collected and maintained in a data base for longitudinal trends analysis.
8. Side effects to medications can be serious and life threatening. Individuals with developmental disabilities can not adequately report signs and symptoms of medication side effects, hence, it is essential that direct care staff, nursing staff and physicians must enhance their ability and understanding of need to monitor all individuals more closely for potential drug reaction when ever a new medication is added, drug dose

increased or decreased, when a new behavioral issue develops and when functional decline is observed.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Review of Following Documents**: 1. Record reviews of Individuals #7, #51, #57, #84, #99, #107, #146, #217, #223, #251, #324, #378, #403, #436, #439, #465, #508, #551, #557, #571, #586, #621, #634, #661, #755, #765, and #771 2. A list of all therapy and/or clinical staff (OT, PT, SLP, RD,), and Physical and Nutritional Management (PNM) team members, including credentials 3. Richmond Plan of Improvement (POI) 5/17/10 4. Richmond Supplemental Plan of Improvement (SPOI) 7/5/10 5. Policies, procedures, and/or other documents related to Physical and Nutritional Management (Policy #013 dated 1/31/2010 and #012 dated 1/31/2010) 6. Curriculum vitae (CVs) for PNMT members 7. A list of continuing education sessions or activities participated in by PNMT members since 1/2010 8. Minutes, including documentation of attendance, for the PNMT and NMT meetings (5/2010 to 9/2010) 9. Individual PNMT reports for individuals reviewed above 10. Health Risk Screening forms (Skin Integrity, Injury, Aspiration) used to identify individuals' PNM health risk level 11. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 12. Tools used to assess PNM status and needs 13. A list of PNM assessments and updates completed in the last two (2) quarters 14. Completed Physical Nutritional Management Plans (PNMPs) for all individuals with identified needs 15. Tools used to monitor implementation of PNM procedures and plans 16. A list of individuals for whom PNM monitoring tools were completed in the last quarter 17. Tools utilized for validation of PNM monitoring 18. For the past two quarters, any data or trend summaries used by the facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans 19. Nutritional management plan template and any instructions for use of template 20. Dining Plan template 21. Lists of individuals: (a) On modified diets/thickened liquids; (b) Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; (c) With BMI equal to or greater than 30; (d) With BMI equal to or less than 20; (e) Since January 1, 2010, who have had unplanned weight loss of 10% or greater over six (6) months; (f) During the past 12 months, have had a choking incident;

	(g) During the past 12 months, have had a pneumonia incident; (h) During the past 12 months, have had skin breakdown; (i) During the past 12 months, have had a fall; (j) During the past 12 months, have had a fecal impaction; (k) Are considered to be at risk of choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, with their corresponding risk severity (high, med, low etc.); (l) With poor oral hygiene; and (m) Who receive nutrition through non-oral methods 22. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation during the past year 23. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 24. Tools and checklists used to provide competency-based training addressing: (a) Foundational skills in PNM; and (b) Individual PNM and Dining Plans 25. Information on percent of staff with responsibilities for the provision of direct supports who have completed competency-based training on foundational skills in PNM **Interviews with**: ▪ Gary Sandler OTR, Director of Habilitation Services ▪ Wilma Parker RN ▪ Robyn Partridge BSN ▪ Tran Quan MD ▪ Alice Ramirez, Data Analyst ▪ Kimberly Randel RN ▪ Kelly Sandler RN ▪ DCPS (Four-Trinity, Three-Leon, Four-San Antonio) **Observations of**: ▪ Meals on Trinity, Leon, and San Antonio ▪ Competency Based Webinar (State Office) ▪ Transition times (Leon, San Antonio)
	Facility Self-Assessment: The RSSLC POI reported substantial compliance with zero of 77 Action Steps. None of the eight provisions in Section O were rated as in substantial compliance. Among the action steps determined to not be in compliance included the development of a physical and nutritional management (PNM) team, occurrence of regularly scheduled meetings, identification of individuals who were at an increased risk of PNM decline, presence of a comprehensive assessment, comprehensive physical and nutritional management plans (PNMPs), and presence and implementation of PNMPs. There are many processes that are on the verge of being implemented or have not yet been developed,

	therefore the monitoring team is in agreement with RSSLC's self assessment.
	Summary of Monitor's Assessment: **For Provision O.1**: This provision was determined to be not in compliance. The Physical and Nutritional Management Team was found not to meet the standards identified in the settlement agreement. Currently, the team was only providing assessments once per week and is not addressing system issues. Additionally, the team did not have consistent participation of ancillary members and did not meet in response to potential areas of PNM decline. **For Provision O.2:** This provision was determined to be not in compliance. Individuals who were at risk were not being accurately identified by the existing risk system resulting in individuals being place at an unnecessary risk of harm. Individuals who have had skin breakdown, fecal impactions, or aspiration pneumonia were mostly listed as being at a low risk. Additionally, the two individuals who were listed as high risk were not provided with a comprehensive care plan to mitigate the risk. Assessments were vague and did not provide detailed objective information that lends itself to identification of root cause. This lack of investigation resulted in individuals remaining at risk and not receiving the services they need. **For Provision O.3:** This provision was determined to be not in compliance. All individuals living at RSSLC with identified PNM issues had a document called a PNMP and dining plan. The PNMP was not considered comprehensive or effective due to the lack of information regarding oral hygiene and medication administration. There was also question regarding how functional or valid the PNMPs were due to the lack of comprehensive assessment used in the development process. There were, however, several practices that the Facility should ensure continue, such as positioning instructions for wheelchairs and alternative positioning, transfer instructions, and intake information for meals and snacks. **For Provision O.4:** This provision was determined to be not in compliance. Based on observation of mealtimes, staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. Thirty-one observations demonstrated that staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan which were most likely to prevent swallowing difficulties and/or increased risk of aspiration **For Provision O.5:** This provision was determined to be not in compliance. A major concern of the monitoring team was that although there was evidence of staff training, it did not translate into implementation of the plans designed to mitigate risk and the monitoring designed to ensure implantation was not effective. Additionally, PNM supports for individuals who are determined to be at an increased level of risk were not only provided by staff who had successfully completed competency-based training specific to the individual. There was not a clear process in place to ensure all staff (including pulled staff) were provided

	with person-specific competency based training prior to working with the individual or a method in place that helps the supervisors identify staff who have received the needed individualized training. **For Provision O.6:** This provision was determined to be not in compliance. Monitoring did not cover staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). Currently, monitoring remains focused on mealtime. Expansion towards covering all areas in which the individual is at an increased risk is an area that needs to be addressed. **For Provision O.7:** This provision was determined to be not in compliance. A process was not in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. Based on the review of 19 individual records, the PNM Team did not document progress of individual strategies on a monthly basis to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators for those individuals with the most complex physical and nutritional support needs. **For Provision O.8:** This provision was determined to be not in compliance. Individuals who were enterally nourished did not receive an annual assessment that addressed the medical necessity of the tube and potential pathways to oral (PO) status. During various meetings, it was mentioned that the tube remained appropriate, but no evidence was presented or discussed to indicate that proper assessment of potential pathways to oral intake was conducted.

#	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	The PNM team consisted of a qualified Speech Therapist (SLP), Occupational Therapist(OT), Physical Therapist (PT), Registered Dietitian (RD) and Registered Nurse (RN)but did not consistently include a Physician or Behavior Analyst. Due to the medically high risk nature of the individuals who will be the focus of the meetings, a physician would be needed so that a true comprehensive discussion may be provided and medical implications addressed. Additionally, because many issues associated with physical and nutritional decline are linked to behavioral issues, a behavior analyst would be a valuable member of the team. Based on a review of PNM Team attendance records and meeting minutes dated 10/4/10, 10/7/10, 10/18/10, and 10/25/10, participation was noted by the Habilitation Director, Physical Therapist, Occupational Therapist, Speech Pathologist, PNMP Coordinator, dietitian, and RN Case Manager. Missing from the documentation was the presence of a Physician and Psychologist or Behavior Analyst. Review of facility documentation (Curriculum Vitae(s), copy of current licenses) submitted for each PNM Team standing member did demonstrate the following	NC

#	Provision	Assessment of Status	Compliance
	separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, 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.	qualifications for PNM Team standing members: • In 25 of 25 licenses reviewed, a copy of the license was current. • In 25 of 25 CVs reviewed, experience in respective field was documented. Review of PNM clinical instruction documentation submitted revealed that PNM Team members did have training and professional development in the following areas: • In 25 of 25 individual clinical instruction records reviewed, clinical instruction within the last 12 months related to physical and nutritional supports had been completed. Based on a review of 19 individual records, documentation supported that the PNM Team did not meet regularly to address change in status, indicators of increased risk, clinical data and monitoring results. Individual examples of where the PNM Team did not meet regularly to address change in status, assessment, clinical data and monitoring results included: • Individual #84 was diagnosed with aspiration pneumonia on 5/21/10. There was no evidence of a review by the PST to discuss the incident or assessment to determine cause of the event or to determine if a return to oral intake was a possibility. • Individual #439 was diagnosed with aspiration pneumonia on 7/5/10. There was no HST or PST response to the incident. • Individual #223 was diagnosed with aspiration pneumonia on 1/14/10. No assessment was conducted post incident to fully determine swallow function nor was there evidence of team review • Individual #436 was diagnosed with aspiration pneumonia on 2/19/10 and 7/4/10. There was no evidence of assessment or investigation as to the root cause of the incident. There was also no evidence that the PNM team met to discuss the issue. • Individual #217 had a choking event on 7/13/10. There was evidence that OT observed a medication pass and mealtime but there was no evidence of follow up beyond the observation. There is also no evidence of a comprehensive oral motor assessment to determine if there was a decline in swallow function. RSSLC recently formed a PNM team. As of this review, the team had met 4 times. The primary function of the team at this point had been to review and provide a comprehensive assessment to individuals who are at an increased risk; however there were no clear criteria for determining who is truly at risk. There were multiple issues noted with the current format. One issue was that other than providing assessment, there was no evidence of data analysis, trending, or review of systems. The PNM team	

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		was providing comprehensive assessment to one individual on a weekly basis, then reviewing that individual at the following meeting. While there is a definitely a need to provide such assessment, there is also a need to address PNM issues on a global level to help identify areas of concern within the system and provide direction in an effort to prevent reoccurrence of PNM issues. During the visit, the monitoring team's concerns were shared with the habilitation director who decided to expand the focus of the PNM team. As mentioned later in this report in detail, an assessment is more than an observation. An assessment provides detailed data regarding root cause of current or potential issues and clearly demonstrates a framework for future services or interventions.	
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 was not in place that identifies individuals with PNM concerns. Nineteen of 19 records reviewed did not accurately identify individuals who are at an increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified include: • Individual #436 had multiple pneumonias over the past 8 months but was listed as being only at a moderate level of risk. • Individual #439 had chronic constipation, GERD and a history of aspiration pneumonia within the last 3 months but was listed as being at a low risk. • Individual #557 had a choking event on 9/23/10 but was listed as low risk. • Individual #755 had a choking event on 9/3/10 but was listed as low risk. • Individuals #661, #106, and #169 all had fecal impactions within the last 12 months but all were listed as being at a low risk of constipation Per the risk list provided to the monitoring team, it was noted that there were only 2 individuals identified as being at a high risk. Based on the population living at RSSLC and the observations conducted, this number did not accurately represent those who are at risk. Additionally, the two individuals who were identified as high risk as were not provided with individualized nursing care plans (NCP) that addressed the risk. For example: • Individual #586's NCP referred to her as "him" at times and referenced her as eating orally when she received enteral nutrition. The NCP also wasvague at times and did not provide detailed information regarding frequency of monitoring vital signs and lung sounds. • Individual #84's NCP did not provide detailed information regarding head of bed elevation, frequency of vitals and/or lung sounds.	NC

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		There was also no evidence of collaboration between nursing and habilitation services with regards to development of the care plan nor was there reference to the PNMP which contained much information that would assist in mitigating the risk. The care plan did not meet general standards of care as it was not specific to the individual nor did it list effective solutions to mitigating the risk. The lack of identification as well as the lack of individualization and collaboration results in an increased risk of harm. Based on a review of 19 individuals, 19 of 19 Individuals were not provided with a comprehensive assessment by the PNM team that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day and during nutritional intake. Currently the OT components regarding oral care and medication administration were missing from the assessment process. Additionally, the oral motor section of the assessments continued to be vague and did not provide clear objective information regarding swallow status and cannot be considered an assessment. For example: • Individual #508's OT/PT assessment (4-10) stated the individual has poor oral motor skills but did not state or provide information regarding the different components of the oral motor status (i.e., lingual or labial range of motion, and anterior-posterior propulsion). • Individual #51's OT/PT assessment (10/9/10) stated the individual's teeth are mostly intact but did not provide more detail regarding dental status. • Individual #661's OT/PT assessment (8/17/10) stated that head of bed should be elevated but did not provide degree of elevation or why elevation is needed. The failure to provide appropriate assessments regarding medication administration and oral care results in an unnecessary increase in risk. An example of this is Individual #217 who choked on a pill during med pass. This is an event that could be avoided with assessment to determine positioning and pill size. In addition, assessments that were occurring outside of the annuals were merely observations and were not detailed enough to establish root cause or direct future treatment and therefore cannot be considered an assessment. These observations were listed within the IPNs or Habilitation Services Notes. The location of where the observations were listed was inconsistent and at times was listed in one or the other and at other times listed in both. Examples of this issue may be found in the records of Individuals #217 and #634. Review of 19 records involving individuals revealed: • In 19 of 19 records reviewed (100%), there was no documentation of PNM review/analysis of the findings, including but not limited to relevant discipline-	

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		specific assessment(s), PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary. The summary did not address: o Oral care. o Medication administration. o Mealtime strategies in a method that is clear as to why the strategies are relevant. o Rationale and Justification for Head of Bed Elevation. Head of Bed Assessment is an area that should be highly individualized and based upon multiple factors which include but are not limited to tolerance, ability to maintain position, optimal position for GERD, and prevention of deformity. Currently, Head of Bead elevation is generally assigned and is not clearly based on assessment. Individuals who received direct and indirect PNM and OT/PT supports received annual OT/PT assessments in addition to medical, nursing, and nutritional assessments provided annually to each individual. Assessment was not specifically driven by level of health risks. These were discipline-specific assessments with the exception of the OT/PT assessments, and little collaboration at the time of assessment was noted among professional staff for any individual, and certainly not for those at highest risk. In 19 of 19 records reviewed, there was lack of congruency between Strategies, Interventions, and Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. Congruency was not noted with regards to Oral Motor/Swallowing or head of bed elevation as it is unclear as to what the rationale or justification was for multiple dining strategies or positioning interventions. For example: • Individual #661 should have his solids and liquids alternated. There was no description as to what swallowing issues this strategy addressed. • Individual #661 head of bed should be elevated but there was no indication of assessment or why the stated degree of elevation was appropriate. • Individual #251 should be offered drinks at the beginning of the meal. It is unclear as to why this intervention is needed. All recommendations should have clear justifications as to why they are appropriate and the issue in which they are designed to address. As of this review, there was not a clear system in place that promoted the discussion, analysis and tracking of individual status and occurrence of health indicators associated with physical and nutritional risk. Per record review, there were multiple incidents in which there was no documentation indicating any decline or noted issues until the	

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		individual became so ill that hospitalization was required. Examples of this occurring include individuals #571 and #436. Another example is Individual #634 who on 4/28/0 coughed up blood but there was no evidence that the physician was notified. Additionally, during mealtime observations, potential signs of aspiration by individuals #146 and #765 in the form of coughing with struggle were observed by the monitoring team. Staff was observed not reacting to the potential signs. Upon review of the record, there was no documentation or notification to nursing, habilitation services or the physician. This lack of reporting lends itself to issues becoming severe due to lack of awareness and inaction and presents itself as an overall acceptance of decline and illness. The absence and/or lack of detailed documentation resulted in difficulty following the plan of care and determining whether or not all avenues had been covered. Examples of this lack of documentation included lack of reporting by DCPs (as noted directly above) and the lack of detail by professionals in their assessments and notes in the IPN and Hab Services sections of the Active Record.	
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 living at RSSLC with identified PNM issues had a document called a PNMP and dining plan. The PNMP was not considered comprehensive or effective due to the lack of information regarding oral hygiene, and medication administration. Based on a review of 19 individual PNMPs, individuals were not provided with a comprehensive PNMP. • In zero of 19 PNMPs reviewed, strategies for medication administration were included. • In zero of 19 PNMPs reviewed, strategies for oral hygiene were included. • In zero of 19 PNMPs, head of bed elevation contained the degree in which the person should be elevated. • In zero of 19 PNMPs reviewed, clinical indicators associated with PNM decline were present. • In zero of 19 PNMPs reviewed bathing/showering positioning and instructions were included. There were, however, several practices that the Facility should ensure continue, • In 19 of 19 PNMPs reviewed, positioning instructions for wheelchair and alternate positions instructions were included as applicable. • In 19 of 19 PNMPs reviewed, transfer instructions were included as applicable. • In 19 of 19 PNMPs reviewed, the mealtime/dining plan included intake information for mealtime and snacks • In 19 of 19 PNMPs reviewed, the mealtime/dining plan included food/fluid textures as applicable.	NC

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		• In 17 of 19 PNMPs reviewed, the mealtime/dining plan included behavioral concerns related to intake. • In 19 of 19 PNMPs reviewed, individual adaptive equipment was included. While it is positive that the PNMPs contained the information above; there is concern by the monitoring team that the information regarding mealtime strategies was not built upon solid assessments due to the lack of detail contained within the completed assessments. In 19 of 19 records reviewed (100%) PNMPs were incorporated into the Personal Support Plan, but as mentioned previously, the PNMPs were not comprehensive as they did not contain information regarding oral care and medication administration as well as specifics regarding head of bed elevation, nor are there signs of integration across disciplines. In 19 of 19 records reviewed (100%), there was evidence that the PNMPs were reviewed annually at the PSP meeting. In 10 of 19 records reviewed, it was unclear as to whether the PNMPs were updated as needed due to at times being a lack of assessment upon an individual's return from the hospital. Examples of when PNMPs were or were not reviewed and updated as indicated by a change in the individual's status, transition (change in setting) or as dictated by monitoring results. • Individual #436 was diagnosed with aspiration pneumonia on 2/19/10 and 7/4/10. There was no evidence of assessment or investigation as to the root cause of the incident. There was also no evidence that the PNM team met to discuss the issue upon the individual's return from the hospital.	
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	Based on observation of mealtimes, staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. Thirty-one observations demonstrated that staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan which were most likely to prevent swallowing difficulties and/or increased risk of aspiration in the following areas: • In eightof 31 observations, staff were following mealtime plans. • In 15of 21 observations, staff were following wheelchair positioning instructions. • In six of 14 observations staff were following alternate positioning instructions. • In five of five observations staff were following transfer instructions,	NC

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	provoke swallowing difficulties.	Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan: • Individual #621 was observed collapsed forward resulting in poor positioning for respiration and safe eating when the PNMP called for upright positioning. • Individual #765 was observed being fed with his neck severely hyperextended resulting in an increased risk of aspiration secondary to an exposed airway when the PNMP stated that his head should be in a neutral position. Per interview with four DCPs on Trinity, three DCPs on Leon and four DCPs on San Antonio, most staff understood various techniques designed to ensure safe eating but did not consistently understand the rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP, the schedules for implementing strategies, or adaptations of those techniques prescribed for specific individuals. Failure to fully understand why interventions are important lends itself to a decreased sense of awareness of how lack of implementation may result in harmful consequences. • In 10 of 11 interviews with staff, staff could identify the location of PNMP and/or mealtime plan • In 10 of 11 interviews with staff , staff could describe individual-specific PNMP strategies • In five of 11 interviews with staff, staff could explain the rationale or reasoning behind the strategies that were implemented • In six of 11 interviews with staff , staff could describe the schedule for implementation of PNMP strategies • In five of 11 interviews with staff , staff stated they had received individual-specific training for PNMP strategies Examples of direct support professionals who were not able to describe the following PNMP indicators: • DCP on Leon and Trinity stated that strategies to mitigate the risk associated with aspiration were limited to dining only. • DCP on Leon was not able to state why alternating liquids and solids decreased the risk of choking. • DCP on Trinity was not able to state why it was important to provide individual #403 liquids at the end of the meal.	
O5	Commencing within six months of	Staff were provided with general competency-based foundational training related to all	NC

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	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.	aspects of PNM by the relevant clinical staff. Review of the Facility's training curricula revealed that it did include PNM training in the following areas: • Body mechanics • Handling techniques • Optimal alignment and support in seating systems and alternate positions • Mechanical lift transfers • Manual transfers approved by facility policy • Mealtime positioning • Food and fluid consistency • Safe presentation techniques for food and fluid • PNMPs. Per documents received (Section XII #30), all staff had been provided with competency based PNM training and all staff were scheduled to receive annual PNM refresher training, although that had not been provided yet. In addition to the PNM training, staff also receives annual refreshers regarding Ambulation, and Lifting/Transfers. Training forms from the last quarter indicated staff had received initial PNM training but had not yet received the annual refresher training. Per habilitation director, this will accomplished by the next visit. Competency-based training focuses on the acquisition of skills or knowledge and was represented at RSSLC by trainee demonstration of skills or by multiple choice test (with or without trainee demonstration, depending on skill or knowledge addressed),. Skills based competency based check offs were limited to the lifting and transfers class. All other areas of PNM were scored based on a multiple choice test and did not include demonstration. Staff were provided person-specific training of the PNMP by the appropriate trained personnel. Habilitation Therapies staff reportedly provided competency-based training for home supervisors, and PNMP coordinators. These staff were then responsible to train their staff. Documentation of the home supervisors' training was maintained by the therapy department, and sign-in sheets for in-services provided to direct care staff was maintained by the home. Staff training provided was not consistently competency-based. A major concern of the monitoring team was that although there was evidence of staff training, it did not translate into implementation of the plans designed to mitigate risk, and the monitoring designed to ensure implementation was not effective.	

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		Additionally, Per interview with Habilitation Director, PNM supports for individuals who are determined to be at an increased level of risk were not always provided by staff who had successfully completed competency-based training specific to the individual. There was not a clear process in place that ensured all staff (including pull staff) were provided with person-specific competency based training prior to working with the individual nor a method in place that helps the supervisors identify staff who have received the needed individualized training. During the visit, the monitoring team had the opportunity to attend the competency based webinar which was organized by Karen Hardwick of State Office. The purpose of the meeting was to review and provide feedback regarding competency based forms for lifting and mealtime. Another topic of conversation was how to better improve implementation of strategies during mealtime. Discussed forms were placed on a shared drive so that all the state centers could review and provide feedback. This was a positive step not only as it relates to overall care but to improve consistency between SSLCs.	
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.	Monitoring did not cover staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). Currently, monitoring remains focused on mealtime. Per conversation with the habilitation director, the expansion towards covering all areas in which the individual is at an increased risk is an area that needs to be addressed. One reason for the lack of progress in this area may be due to the habilitation director being gone for approximately three months assisting another center. This is an area that must be addressed as quickly as possible due to the high risk of aspiration occurring outside of dining. A review of 127 Facility monitoring reports from July 1, 2010 to 10/15/10 documented that staff were not being monitored in all aspects in which the individual was determined to be at increased risk. Examples of PNM activities that were not being monitored: • Oral Care • Medication Administration • In-Bed Positioning • Bathing Examples of PNM activities that were being monitored: • Mealtime Interventions • Mealtime Positioning • Adaptive Equipment	NC

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		Out of the 127 monitors completed, six deficits were noted with adaptive equipment and 16 deficits were noted regarding implementation of PNM strategies and/or interventions. Based on the monitoring team's observations, the number of issues that were noted by RSSLC were not in line with the frequency of issues noted by the monitoring team and demonstrate that monitoring was not done adequately to ensure interventions are implemented accurately and individuals are safe. A policy/protocol that addressed the monitoring process was recently developed. This process was designed to increase the level of monitoring for those individuals who were at an increased risk. Due to this policy just being implemented, changes in monitoring had not yet been implemented.. As with PNM monitoring, there is concern over the accuracy of the monitoring due to lack of consistency between what was found in monitoring team observations and what was identified by the PNMP coordinators.	
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 was not in place that promoted the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. Based on the review of 19 individual records, the PNM (NMT) Team did not document progress of individual strategies on a monthly basis to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators for those individuals with the most complex physical and nutritional support needs. While PNMPs were reviewed at the PSP, there was not a system in place that clearly monitored the effectiveness of the plan by tracking clinical indicators such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response). The PNM team did not utilize PNMP monitoring information in their reviews. Meal observation information was used occasionally. The PNMT did not specifically review aggregated findings across homes for trend analysis to drive system change and training. There was no mechanism to track data for system analysis in order to focus training and coaching. There was no system in place to conduct trend analysis to consistently review if interventions had a positive outcome on an individual's health status. They also did not review incidence of health concerns such as aspiration pneumonia, use of bowel management aids, weight loss/gain, falls, fractures, and so forth over time to address system outcomes as a result of interventions and supports.	NC
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an	Review of nine individuals who were enterally nourished revealed these individuals did not receive an annual assessment that addressed the medical necessity of the tube and potential pathways to PO status. During various meetings, it was mentioned that the tube remained appropriate, but no evidence was presented or discussed to indicate that	NC

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	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.	proper assessment of potential pathways to oral intake was conducted. Examples of individuals who received enteral nutrition and did not receive an annual assessment: • Individuals #84, #99, #324, #551 and #7 Nine of nine individuals who received enteral nutrition and/or therapeutic/pleasure feedings were provided with a PNMP. This PNMP, however, was missing the same information as listed in Provision O.3. PSPs for the individuals who received enteral nutrition did not clearly document the rationale for the continued need for enteral nutrition. Examples of individual PSPs that did not document the rationale for the continued need for enteral nutrition were: • It was mentioned in the PSP that Individual's #84, #551, #7, and #99 were tolerating tube feedings but did not specify why enteral nutrition was appropriate or possible pathways to PO intake.	

Recommendations:

1. The PNM team consists of qualified SLP, OT, PT, RD, and RN but does not consistently include a Physician or Behavior Analyst. Due to the medically high risk nature of the individuals who will be the focus of the meetings, a physician would be most beneficial so that a true comprehensive discussion may be provided. Additionally, because many issues associated with physical and nutritional decline are linked to behavioral issues, a behavior analyst would be a valuable member of the team.
2. Assessments must be reviewed and revised so that all aspects of physical and nutritional management are addressed in a comprehensive manner. This includes assessing oral care, medication administration and positioning for these activities as well as positioning for improved GERD management and stomach emptying. All recommendations based on these assessments should have clear justifications as to why they are appropriate and the issue in which they are designed to address.
3. Individuals who receive enteral nourishment should be assessed annually to determine appropriateness of continued enteral status and the possible return to oral intake. Assessments must clearly indicate possible pathways to resume oral intake.
4. Ensure the policy and procedure for monitoring defines the process of analyzing monitoring reports and formulating corrective strategies to address specific and/or systemic areas of deficiency.
5. The monitoring system must include a mechanism to ensure that issues and concerns are appropriately identified, recorded and addressed with documentation of resolution. Each identified concern must be addressed via an action plan with evidence of completion such as staff training, submission of work order, and equipment replacement.
6. Validity and accuracy of monitoring should become a focal point until accuracy within the system can be improved.
7. All individuals who are determined to be at an increased risk should only be provided assistance from staff who have received competency based training specific to that individual. Identifying a sister home where all staff and cross training all staff is a possible option.
8. All documentation relevant to the individual's plan of care should be detailed so that those reviewing an individual's history and monitoring care

are easily able to ensure the loop of care was closed (onset to resolution).

9. PNMPs must be expanded to include oral care and medication administration. Strategies should not only include positioning for these activities but strategies and adaptive equipment that will assist in minimizing the individuals' risk.
10. The PNM meeting should be a collaborative meeting in which all parties bring their area of expertise to the table to investigate the etiology of such illness as pneumonia, skin breakdown, and constipation and how to prevent or minimize the reoccurrence. Change of status should result in additional meetings in an effort to provide more comprehensive problem solving and timely implementation.
11. A A data system should be developed so that data regarding clinical indicators as well as focal points of monitoring can be collected for review and analysis by the PNM team. The development of such a system should be a statewide initiative amongst all the centers to ensure that data can be compared and shared for peer review.
12. To ensure accurate monitoring by PNMP Coordinators, they require structured, functional, competency-based training that includes didactic presentation of monitoring strategies and validation of competence through an ongoing "monitor the monitor" process, whereby they are observed during the monitoring process and compared to a licensed clinician. Tracking of this should occur to clearly document that each PNMPC has received the same training and frequency of oversight and review.
13. An assessment should be developed that focuses solely on swallowing since this is an issue that is a major focus of decline. This assessment cannot be done solely through observation of mealtime. Observations of mealtime are vague and do not provide the objective detailed data to be considered an appropriate assessment.
14. A new risk system is imperative in identifying individuals who are at an increased risk. The new policy should be implemented as quickly as possible so those individuals may begin to receive the care that is needed.

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:** The following activities occurred to assess compliance: **Review of Following Documents**: 1. Record reviews of: #7, #30, #51, #57, #84, #99, #107, #113, #146, #173, #185, #217, #223, #251, #268, #286, #324, #360, #378, #403, #413, #418, #436, #439, #455, #465, #470, #477, #508, #551, #557, #571, #586, #607, #621, #632, #634, #649, #661, #755, #765, and #771 2. A list of all therapy and/or clinical staff (OT, PT, SLP, RD,), including credentials 3. Policies, procedures, and/or other documents related to Physical and Nutritional Management,(Policy #013 dated 1/31/2010 and #012 dated 1/31/2010) 4. Curriculum vitae (CVs) for PNMT members 5. Richmond Plan of Improvement (POI) 5/17/10 6. Richmond Supplemental Plan of Improvement (SPOI) 7/5/10 7. Minutes, including documentation of attendance, for the PNMT and NMT meetings (5/2010 to 9/2010) 8. Individual PNMT reports for individuals reviewed above 9. Tools used to screen and identify individuals' PNM health risk level 10. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 11. Tools used to assess PNM status and needs 12. A list of PNM assessments and updates completed in the last two (2) quarters 13. PSPs for the individuals on the list above for whom PNM assessments and updates have been completed in the last quarter 14. Completed Physical Nutritional Management Plans (PNMPs) for all individuals with identified needs 15. Tools used to monitor implementation of OT/PT procedures and plans 16. A list of individuals for whom OT/PT monitoring tools were completed in the last quarter 17. For the past two quarters, any data or trend summaries used by the facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans 18. Nutritional management plan template and any instructions for use of template 19. Dining Plan template 20. Lists of individuals: (n) On modified diets/thickened liquids; (o) Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; (p) With BMI equal to or greater than 30; (q) With BMI equal to or less than 20; (r) Since January 1, 2010, who have had unplanned weight loss of 10% or greater over six (6) months; (s) During the past 12 months, have had a choking incident; (t) During the past 12 months, have had a pneumonia incident; (u) During the past 12 months, have had skin breakdown;

	(v) During the past 12 months, have had a fall; (w) During the past 12 months, have had a fecal impaction; (x) Are considered to be at risk of choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, with their corresponding risk severity (high, med, low etc.); (y) With poor oral hygiene; and (z) Who receive nutrition through non-oral methods 21. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation during the past year 22. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 23. Tools and checklists used to provide competency-based training addressing: (c) Foundational skills in PNM; and (d) Individual PNM and Dining Plans. 24. For the prior 12 months, a list of competency-based training sessions addressing foundational skills in PNM. 25. Information on percent of staff with responsibilities for the provision of direct supports who have completed competency-based training on foundational skills in PNM. 26. Priority List for wheelchair assessment **Interviews with**: ▪ Gary Sandler OTR Director of Habilitation Services ▪ Maria Jean Cuevo PT ▪ Melissa Amores PT ▪ David Taylor OTR ▪ DCPS (Four-Trinity, Three-Leon, Four-San Antonio) **Observations of**: ▪ Alternative positioning on Trinity and Leon ▪ Mealtime Observations on Trinity, San Antonio, and Leon
	Facility Self-Assessment: The RSSLC POI reported substantial compliance with zero of 35 Action Steps. None of the four provisions in Section P were rated as in substantial compliance. Among the areas of noncompliance included adequate number of physical therapist, the presence of a comprehensive assessment, individuals in need receiving an assessment, justification and rationale for interventions, staff training and monitoring. The RSSLC POI consistently indicated that areas were not currently being processed but will be addressed in the coming months. The Monitoring Team is in agreement with RSSLC's determination of noncompliance. Individuals in need of assessment remain in need of assessments. Individuals who have positioning issues and would benefit from new adaptive equipment have not been provided with such equipment.

	Summary of Monitor's Assessment: **Provision P.1:** This provision was determined to be not in compliance. RSSLC had opened up two more positions for PT which should assist in lowering the caseload but these positions had not been filled as of this review. Assessments were completed in accordance to the schedule set forth by RSSLC; however, assessments were not being consistently completed in response to a change in status. **Provision P.2:** This provision was determined to be not in compliance. Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Intervention plans related to positioning were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. Examples of this were Head of Bed (HOB) elevations. **Provision P.3:** This provision was determined to be not in compliance. Plans were not implemented as written and staff were not knowledgeable of the OT/PT plans. Based on interviews of DCPs, staff did not consistently understand rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the OT/PT plans and /or PNMPs. **Provision P.4:** This provision was determined to be not in compliance. A system did not exist that ensures staff responsible for positioning and transferring high risk individuals receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility	The census of RSSLC was 397 at the time of the compliance review. The Habilitation Director was an Occupational Therapist who had been at RSSSLC for the past two years. There were five and a half OTs, three Certified Occupational Therapy Assistants (COTAs), four full time PTs, two Physical Therapy Assistants(PTAs), and 15 PNMP coordinators. There were two PT vacancies at the time of the review. The ratio of therapists to individuals continues to be a concern. The current ratio resulted in limited direct OT/PT services. Based on a review of CVs for each therapy clinician and interviews with therapy staff, the Department did document appropriate qualifications for licensed OTs, PTs, and assistants(copy of current license), as well as for mobility specialists, assistive technology technicians, and fabricators (evidence of specialized training and/or continuing education in the last 12 months).	N

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	assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	Clinical instruction for staff was documented in the following areas in the last 12 months: • NMT/PNMP/Equipment Webinar 2010 • Wheelchair Teleconference 2009 and 2010 • Seating and Positioning for Dysphagia 2010 • Neurological Intervention for Physical Therapy 2009 Although staff were qualified, assessments of individuals identified with therapy needs did not meet current standards. At a minimum, the comprehensive OT/PT assessment addressed only the following elements: • Movement; • Mobility; • Range of motion; • Independence Missing from the plans was a comprehensive section addressing oral care and medication administration. Additionally, the Oral Motor component as well as the justification of HOB elevation were lacking in detail and did not provide sufficient information to be considered an assessment. For examples, refer to Provision O2. Plans were not timely or consistently developed to address issues. For example: • Individual #455w as above ideal body weight (IBW), but there was no exercise program in place. • Individual #778 did not receive a PT review in response to falls occurring on 7/7/10, 7/21/10, and 7/28/10 until 7/30/10. • Individual #346 did not receive a PT review in response to falls occurring on 7/5/2010 and 7/26/10. Per interview with PTs, there was not a clear, reliable system in place to ensure that they were notified of an individual's change in status consistently or in timely manner. Based on record review of 23 individuals who had experienced a change in health or physical status, 23 of 23 individuals had not received a comprehensive OT/PT assessment within 30 days or sooner as indicated to address health and/or safety. Examples include: • Individual #84 was diagnosed with aspiration pneumonia on 5/21/10. There was no evidence of a review by the PST to discuss the incident or assessment to determine cause of the event or to determine if a return to oral intake was a possibility.	

#	Provision	Assessment of Status	Compliance
		• Individual #439 was diagnosed with aspiration pneumonia on 7/5/10. There was no HST or PST response to the incident. • Individual #223 was diagnosed with aspiration pneumonia on 1/14/10. No assessment was conducted post incident to fully determine swallow function nor was there evidence of team review In response to a change in status, assessments were not consistently provided. Instead, short observations were located in the record. , An observation cannot be considered a comprehensive assessment as it does not provide objective data or information to determine root cause of incident. Failure to provide comprehensive assessment places the individual at an increased risk of harm due to the inability to determine the cause of the referral event. There was evidence of communication and or collaboration present in the OT/PT assessments. Based on a review of 23 OT/PT annual and interim assessments (assessments in response to a change in status), zero of 19 were comprehensive from each discipline as indicated. For example: • Individual #508's OT/PT assessment (4-10) stated the individual has poor oral motor skills but did not state or provide information regarding the different components of the oral motor status (i.e., lingual or labial range of motion, and anterior-posterior propulsion). • Individual #51's OT/PT assessment (10/9/10) stated the individual's teeth are mostly intact but did not provided more detail regarding dental status. • Individual #661's OT/PT assessment (8/17/10) stated that head of bed should be elevated but does not provide degree of elevation or why elevation is needed Based on review of 23 OT/PT assessments, 100% included evidence of active collaboration between OT and PT. All included signatures and date of both OT and PT.	
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	Based on review of comprehensive OT/PT assessments or updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans and clinician progress notes for eight individuals receiving OT/PT services, plans were developed within 30 days of the date of the assessment/update as indicated by the assessment. Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Refer to Provision O.1 regarding assessments in response to a change in status.	N

#	Provision	Assessment of Status	Compliance
	as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Intervention plans related to positioning were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. Examples of this are HOB elevations in which it is simply stated that individuals require a certain degrees of elevation but there is no evidence that assessment was provided in an effort to make the determination. Based on reviews of PNMPs and other positioning plans for 23 individuals, equipment was specified for 23 of 23 plans reviewed. Individuals receiving direct services were consistently reviewed by OT/PT. The problem was that documentation was not consistently detailed to allow for identification of decline or progress. For example, Individuals #607, #185, and #113 were receiving occupational therapy but the notes simply state what services the person is received and did not include indicators of status or evaluations of progress or decline. Individuals not receiving direct services were not consistently reviewed by OT/PT should there be a change in status. Refer to Provision O.1 for additional information. Additionally, individuals who were referred to restorative care (care provided by PNMP Coordinators) did not have their data collected in a manner that shows decline or progress. Data were collected either by sign off or by simple stating that the activity occurred. Data should be measurable (i.e., recording distance ambulated) so that it can easily be determined whether or not there is a need for repeat consultation by the therapist.	
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.	Based on observations of OT/PT interventions of all PNMPs or other interventions, plans were not implemented as written for nine of 15 individuals reviewed in the sample. Some examples of plans not implemented as written included the following: • Individual #789 was observed with feet hanging off the chair with no support. • Individual #360 was observed on the individual's back when scheduled to be in right semi-sidelying position. • Individual #649 was observed in left semi-sidelying position when scheduled to be on her right side. Based on interviews of DCPs, staff did not consistently understand rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the OT/PT plans and /or PNMPs.	N

#	Provision	Assessment of Status	Compliance
		Based on interviews with 11 direct support professionals: • In 10 of 11 interviews with staff, staff could identify the location of PNMP and/or mealtime plan • In 10 of 11 interviews with staff , staff could describe individual-specific PNMP strategies • In five of 11 interviews with staff, staff could explain the rationale or reasoning behind the strategies that were implemented • In six of 11 interviews with staff , staff could describe the schedule for implementation of PNMP strategies • In five of 11 interviews with staff , staff stated they had received individual-specific training for PNMP strategies Examples of direct care professionals who were not able to describe the rationale for OT/PT interventions and recommendations: • DCP on Trinity was not able to describe rationale for maintaining appropriate elevation and the impact it had on reflux management. • DCP on San Antonio was not able to describe why individuals used modified dining equipment. • DCP on Leon was not able to describe reasoning behind alternate positioning. As with physical and nutritional supports, the failure of staff to understand the consequences associated with non implementation of interventions results in an overall environment where staff are not knowledgeable of the disorders or diseases that they are responsible for treating therefore increasing the risk to the individual.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of	A System existed to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology; however, not all individuals had received the supports that they need. As of this review, 170 individuals utilized wheelchairs as a means of transport. Eighty evaluations had been completed and wheelchairs provided, 41 were scheduled to be completed, and 19 were in various stages of production. A policy/protocol that addressed the monitoring process was recently developed. This process was designed to increase the level of monitoring for those individuals who were at an increased risk. Due to this policy just being implemented, changes in monitoring had not yet been implemented.. As with PNM monitoring, there is concern over the accuracy of the monitoring due to lack of consistency between what was found in monitoring team observations and what was identified by the PNMP coordinators. A system does not exist that ensures staff responsible for positioning and transferring high risk individuals, receive training on positioning plans prior to working with the	N

#	Provision	Assessment of Status	Compliance
	each individual; and the implementation by direct care staff of these interventions.	individuals. This includes pulled and relief staff (Refer to Section O-5).	

Recommendations:

1. The current assessment format needs to be reviewed to determine if it is sufficiently comprehensive to identify the needs of the individuals at RSSLC. Special care should be given to the OT/PT relevant areas of oral care, medication administration and head of bed elevation.
2. Changes in status should trigger an automatic OT/PT assessment or review if related to area of practice (i.e.., fecal impaction, skin breakdown, falls, aspiration, pneumonia, and choking, and/or neurological event). The action taken by OT/PT should be clearly documented and followed to resolution. Observations are not assessments and do not provide the needed objective data to allow for comparative analysis or to appropriately direct services.
3. Individuals receiving direct services by OT/PT should be provided with detailed notes so that progress or lack of progress is evident.
4. A process should be implemented that ensures all staff are provided with individualized competency based training prior to working with individuals who are considered to be "High Risk" or require specialized techniques and/or interventions.
5. Formalize the monitoring process so that it clearly defines the responsibilities of all participants.
6. Ensure the policy and procedure for monitoring define the process of analyzing monitoring reportsand formulating corrective strategies to address specific and/or systemic areas of deficiency.
7. The monitoring system must include a mechanism to ensure that issues and concerns are appropriately identified, recorded and addressed with documentation of resolution. Each identified concern must be addressed via an action plan with evidence of completion such as staff training,
8. To ensure accurate monitoring by PNMP Coordinators, they require structured, functional, competency-based training that includes didactic presentation of monitoring strategies and validation of competence through an ongoing "monitor the monitor" process, whereby they are observed during the monitoring process and compared to a licensed clinician. Tracking of this should occur to clearly document that each PNMPC has received the same training and frequency of oversight and review.
9. Develop treatment plans that have specific measurable and functional goals. Ensure that documentation relates to those goals. Consider integration of these into the PSP process. Interventions should begin to shift to skill acquisition rather than foundational supports via assistive equipment and the PNMPs. These may be accomplished via direct service as well as collaboration in the development of training plans in other areas including the home and day/work programs.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI) 5/17/10 2. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10 3. List of individuals who are current with all dental services 4. List of individuals who are referred for sedation referral 5. List of individuals who are pending dental treatment 6. TIVA dental list 7. Dental Staff qualifications 8. Behavior incident report (dental) 9. Periodontal Chart 10. Oral hygiene care plan 11. Dental summary form 12. Dental appointment – no show report 13. Oral surgery instructions 14. Denture and partial care 15. Discipline CLDP Summary form 16. Physicians orders for Biotene toothpaste 17. Physicians order for Fluoride gel treatment 18. State policy 015 for Dental Services 19. List of annual duties 20. List of weekly duties 21. List of monthly duties 22. List of daily duties 23. List for emergency procedure 24. Document for ICF/MR compliance 25. Document for material safety data sheets 26. Document for non-dental staff injury 27. Document stating "policy and procedure, dental clinic" 28. Document that states "protocol for oral sedation" 29. Document that states "radiation policy" 30. Document that states "sterilization policy" 31. Document that states "volunteers" 32. Disclosure and consent for endodontic therapy 33. Disclosure and consent for deep scaling and root planning 34. Statement describing barriers to dental care 35. Statement regarding external dental services 36. List of individual who received emergency dental services since April, 2010 **37.** PSPs for the following individuals**:** #783, #694, #167, #478, #677, #747, #770, #140, #547, #369,

	#783, #694, #167, #478, #677, 683, #161, #377, #471, #407, #723, #124, #96, #471, and #390 **People Interviewed:** NA **Meeting Attended/Observations:** 1. Annual PSP meeting, October 27, 2010 2. Observation of individuals at all living areas
	Facility Self-Assessment: The Facility recognized that, at the time of the review, it was not in compliance with Provision Q of the Settlement Agreement. The Facility recognized rate limiting factors involved in dental services. Leadership in dental services had identified the Facility's need to enhance external consultation services and is engaged with local dentists to ensure that additional resources are in place by January, 2011. The Facility had also reported headway ensuring a robust on-site TIVA program that facilitates the delivery of quality, on-site, services. Dental Services utilized an excellent "Behavior Incident Report".
	Summary of Monitor's Assessment: Scheduling conflict of the monitoring team and the Facility's dentist resulted in no face-to-face meeting to discuss dental services while at the Facility. The Facility reported that it remains non-compliant with both sections, Q1 and Q2. The monitoring team had an opportunity to review documents to learn of practice standards set fourth by the dental clinic and reviewed PSP and attended a annual PSP meeting to determine the PSTs involvement in dental services. The monitoring team noted that many of the provided documents were newly developed outlines of policies and procedures for dental services. The monitoring team also identified through document review that dental service had a limited referral system and did not utilize mechanical or physical means to safely support individuals during dental procedures. As noted in Section J, programs to minimize need for sedation were in place, but there was a lack of involvement of the PST in decisions about sedation and integration of these programs into the PSP. Importantly, following review of annual PSP, the monitoring team notes a significant lack of involvement of dental issues in general through the team process. The monitoring team does recognize that Dental Services at the Facility was managed well professionally, had acceptable documentation practices, and utilized an excellent behavior incident report. The monitoring team concurs with the Facility's self assessment and has determined that the Facility is not in substantial compliance with section Q of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of	According to documents reviewed, the Facility had adopted the guidelines promulgated	N

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	the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	by the American Dental Association for Persons with Developmental Disabilities. The monitoring team, however, has not had an opportunity to review dental records to determine their actual implementation. Because of limited referral services for cases that require general anesthesia and/or a surgical facility, dental services were currently backlogged. The monitoring team notes that the Facility was in need of additional referral resources and according to the Facility's Dentist, contract negotiations were underway and they anticipate having an additional contract in place by the beginning of 2011, with a local provider. As reported by the Facility's Dentist, there were 22 individuals pending dental services. The monitoring team did not assess the collaboration or involvement of the primary care provider's role in managing dental services and will focus on this issue during subsequent reviews. The issue of the use of bisphosphonates, used for the treatment of osteoporosis, and prescribed dental treatments was explored by the monitoring team. Bisphosphonates are a potential cause of osteonecrosis of the jaw, which can be exacerbated by certain dental procedures, such as tooth extraction. The chance of developing osteonecrosis of the jaw is rare; however, it is a serious condition. The Facility did not have a policy in place specific to providing dental services to persons receiving bisphosphonates. The Facility currently relied on the Facility's Dentist to provide emergency dental services. Subsequently, the Dentist carries a pager and is responsible to respond 24/7 to dental emergencies. As reported by the Dentist, there was only one dental emergency reported this year and this case was triaged by the dentist immediately. The monitoring team is concerned with the "on-call" burden of the Dentist. Upon general observation of individuals at the living area, many individuals appeared to have food particles attached to their teeth, at least one hour following their dining experience.	
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;	Following review of PSP reports and attending an annual PSP meeting, the monitoring team notes that dental services were not assertively incorporated into the PSP process at the Facility. The PST focused mainly on the consent process for sedation and dental treatment but was not aware of the individual's needs secondary to dental services, nor was there meaningful discussion by the PST specific to sedation issues and desensitization. The PST did not comment on important issues such as oral hygiene at the living area, or general dental issues such as gum disease and decay. As noted by dental services, behavioral issues were a significant barrier to dental services. In	N

#	Provision	Assessment of Status	Compliance
	provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	planning the PSP, the PST did not attend to potential benefits of using appropriate physical and/or mechanical supports, as part of a structured behavior approach to providing dental services. The dentist determined when pre-treatment sedation would be prescribed without prior discussion by the PST. The Facility did have programs (developed by the psychologists on the PSTs) in place to minimize the future need for sedation. Many times, but not always, the core of the program consisted of gradual familiarization with the dental clinic and apparatus. Since much of the desensitization work took place in the dental clinic area, the dental suite area was reserved for one afternoon each week for the administration of dental desensitization protocols. While this is a commendable program, the Facility needs to ensure PST involvement and integration of such services into the PSP.	

Recommendations:

1. Following review of the use of bisphosphonates in those prescribed dental procedures at the Facility, the monitoring team strongly recommends that a specific policy be developed that ensures that this issue is addressed by the dentist prior to any dental procedure and most important, that the potential risks are clearly delineated in the consent process, prior to treatment. The monitoring team is not against the use of bisphosphonates for approved purposes; however, it would like to ensure that professional staff, the IDT and the legally responsible person are all cognizant of the known risk.
2. The monitoring team recommends that all documents provided to them for review and considered by the Facility to be policies, be reviewed for comprehensiveness, and when complete ensure that they become officially sanctioned local policies and that appropriate training is provided to staff.
3. It is imperative the dental issues be immediately incorporated into the team process through an efficient mechanism that enables the team to fully understand each individual's dental issues, dental service required and specific program that ensures each individual receives adequate oral hygiene at the living area. During subsequent reviews, the monitoring team will focus attention at the living area to assess the delivery of regular and quality oral hygiene.
4. Dental and behavioral services must enhance their partnership in developing strategies to enhance delivery of services to persons with challenging behaviors. It would be advantageous to reach out to specialty clinics who provide services to adults with developmental disabilities and consider some of the current methods to address these challenges.
5. The monitoring team recognizes that the frequency of dental emergencies at the Facility is low; however, the Facility must review its dental emergency procedure and ensure appropriate back-up for the dental emergencies is enhanced. Once possible mechanism to address dental emergencies, in the event the Dentist is unavailable is to have the individual triaged through the local emergency department. Assessment for emergency surgery, antibiotics and analgesics could be made at the emergency room.

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:** The following activities occurred to assess compliance: **Review of Following Documents**: 1. Record Reviews of Individuals #71, #84, #99, #106, #135, #169, #185, #290, #321, #428, #482, #508, #p57, #607, #613, #651, and #661 2. RSSLC Policy 016) 3. A list of people with Alternative and Augmentative Communication (AAC) devices 4. AAC evaluation and Speech Language assessment template 5. Richmond Plan of Improvement (POI) 5/17/10 6. Richmond Supplemental Plan of Improvement (SPOI) 7/5/10 7. Five (5) most current AAC and SLP assessments conducted by each therapist, and corresponding PSPs. 8. Monitoring tools template for ACC and SLP programs 9. Communication dictionaries for individuals identified as having decreased communication 10. AAC-related spreadsheets 11. List of individuals receiving direct speech services, and focus of intervention 12. Priority List for San Antonio **Interviews with**: ▪ Kendra Robbins SLP, Lead Speech Pathologist ▪ Gary Sandler OTR, Director of Habilitation Services ▪ DCPs (Four-Trinity, Three-Leon, Four-San Antonio) **Observations of**: ▪ Transition times on Leon, San Antonio, and Trinity ▪ Mealtimes on Leon, San Antonio, Trinity
	Facility Self-Assessment: The RSSLC POI reported substantial compliance with zero of 35 Action Steps. None of the four provisions in Section R were rated as in substantial compliance. Among the areas of noncompliance included adequate number of Speech Pathologists, identification of individuals' communication needs, collaboration of Speech and Behavior Support Services, comprehensive assessment, and implementation of communication strategies. The RSSLC POI consistently indicated that areas were not currently being processed but will be addressed in the coming months. The Monitoring Team is in agreement with RSSLC's determination of noncompliance. Individuals in need of assessment remained in need of assessments. Individuals who are nonverbal and may benefit from an AAC device were not being provided with that opportunity thus limiting their ability to be an active participant in the environment.
	Summary of Monitor's Assessment:

	Provision R.1: This provision was determined to be not in compliance. The current ratio for Speech Pathologist to clients was approximately 1 to 66. This ratio may be functional once all systems have been revised and implemented but is not enough to address the issues that have been identified by the Settlement Agreement. **Provision R.2:** This provision was determined to be not in compliance. The Communication Assessment did not consistently address expansion of current abilities and development of new skills. A new assessment was developed but was not implemented during this review. **Provision R.3:** This provision was determined to be not in compliance. AAC devices were not consistently portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs. **Provision R.4:** This provision was determined to be not in compliance. RSSLC was monitoring the presence and working condition of the AAC devices but was not monitoring whether or not the devices were effective and or meaningful to the individuals.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	RSSLC currently had five SLPs and will have six SLPs November 1, 2010. This resulted in an average caseload of 66 individuals. Due to the demands of the Settlement Agreement, the need to reassess all individuals and implement AAC devices, the ratio is too high to ensure timely implementation of the needed services. Seventeen out of 17 records reviewed indicated individuals with identified language difficulties were not receiving active Speech Treatment or participating in a Speech program. Additionally, Communicative aids and speech generated devices (simple and complex) had not been provided to individuals who have decreased language abilities. Examples of Individuals with identified Speech or language difficulties not receiving services: • Individuals #135, #661, #84, #169, #557, #613, #651 have decreased expressive and receptive speech but there was no evidence of programs in place to address this issue.	N
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	SLPs were in the process of developing a priority list for AAC evaluation. Although incomplete, the monitoring team was able to review a portion of the list. The list identified individuals as being as priority 1, 2, 3, 4 and 5. Descriptions of these levels are as listed: • Priority 1-Nonverbal individuals with positive behavior supports(PBS) and aggressive behaviors	N

#	Provision	Assessment of Status	Compliance
	identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	• Priority 2-Nonverbal individuals with PBS without aggressive behaviors • Priority 3-Nonverbal individuals without PBS • Individuals with severely distorted speech • Priority 5-other Per the priority list, all individuals will be assessed by 2013. This is an unreasonable timeframe as many individuals who are nonverbal or have identified speech difficulties will go without proper assessment for multiple years. Seventeen of 17 records reviewed (100%) indicated individuals identified with severe expressive/receptive language did not have AAC investigated and assessed. Examples of individuals diagnosed with severe language difficulties where AAC was not assessed or investigated included: • Individuals #106, #169, #557, #607, and #428 all were listed as having severe language deficits but had not received proper assessment. In zero of the 17 records reviewed, the Communication Assessment addressed the generally required areas of: • Verbal and nonverbal skills, • Expansion of current abilities, • Development of new skills. and • Whether the individual requires direct or indirect Speech Language services. Examples of the communication assessment not addressing all areas included: • Individuals # 290, #428, #482, #661 did not have assessments that clearly identified strengths associated with the individual's current communicative status. The assessments currently in place were vague and did not provide objective data regarding communicative abilities nor did they effectively explore potential methods to expand or develop new language. Per the lead Speech Therapist, this is an area that should be addressed with the new assessment document. This new document will be reviewed during the next visit. If receiving services, direct or indirect, the individual was not provided a comprehensive Speech-language assessment at a frequency that ensures relevance and appropriateness of goals. For example: • Individuals #71, #185, #321, #613, and #651 were listed as receiving direct services but assessments were not provided annually, resulting in lack of ability	

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		to track progress. Identification of behavioral difficulties and communication difficulties and the relation between the two and how communication can have a direct impact on reducing inappropriate behaviors is an area that is beginning to be explored at RSSLC but has not materialized fully Goals written by the Speech Pathologist (SLP) were not consistently tracked and data acquired regarding the goal analyzed by the SLP. Although the goals and intervention plans were at times written by the SLP, the SLPs did not consistently follow an individual's progress resulting in goals that may become stagnant over time due to lack of progress to the individual. Communication dictionaries were developed with input from the team. This dictionary is to be utilized by staff in an effort to improve interaction and understanding of those individuals who are nonverbal. Discussion with DCPs at Trinity, Leon, and San Antonio indicated that five of 11 staff were not knowledgeable of these dictionaries or their contents.	
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.	Results from the speech assessment were only mentioned in the PSP. Rationales and descriptions of communication interventions regarding use and benefit were not clearly integrated into the PSP. Strategies were sometimes listed but these strategies were not consistently integrated into Action Plans or activities of daily living. This lack of integration results in a lack of generalization of objectives from formal training programs into daily life due to the limited amount of time in which the program is run and the variety of activities in which it is trained. For example, teaching use of a symbol or language card or communication device in a formal setting should be done in conjunction with, or with a formal and approved plan to implement when a specific criterion is met, the use of the card or device in daily living (such as a sign or symbol for "please" or "break" being taught in a formal setting but also used and prompted in the residence or work site to request something or ask for a break). Zero of the 17 records reviewed had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated: • Individual # 482's PSP stated that he is nonverbal but did not provide information on how to expand or integrate communication strategies into the daily schedule. • Individual #508's PSP stated to use communication skills but did not state what these skills were and how they would be implemented across all settings.	N

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		Four of four observations did not have communication strategies integrated into the daily schedule. Examples of Communication interventions not being integrated into the daily schedule • Common area devices in the dining rooms and hallways were not observed to be used on San Antonio, Leon, or Trinity. • Communication pages regarding dining were not utilized by staff on San Antonio. Zero of 17 records reviewed clearly indicated how the individual communication goals or recommendations were functional and meaningful to the individual and how it improved his/her daily living. DCPs interviewed were not knowledgeable of the communication programs as evidenced by: • In five of 11 interviews with staff, staff could not describe general communication strategies. • In eight of 11 interviews with staff, staff could not describe the schedule for implementation of communication strategies. • In seven of 11 interviews with staff, staff stated they had not received individual-specific training for communication strategies. • Nine of 11 interviews with staff, staff could not describe general opportunities to enhance communication • As stated in R2, staff were often unfamiliar even with communication dictionaries for the individuals they supported. AAC devices covering common aspects of daily living were not readily available or present in common areas. Four of the four homes had general AAC devices present in the Common areas, however the presence of the devices were limited to only a few per home. Zero of the four common area AAC devices contained clear directives on how staff should utilize general AAC devices. Four observations (100%) demonstrated that staff did not utilize common area AAC devices.	
R4	Commencing within six months of	Monitoring was conducted once a month and focused on the presence of the AAC device,	N

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	the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	the working condition, and implementation but did not assess whether the device was effective in assisting in the individuals with improving their communicative abilities. The monitoring was conducted by the speech therapists and a PNMP coordinator. As with other areas of monitoring, data acquired from the forms were not gathered and assimilated for analysis or trending. Additionally, the SLPs did not consistently follow an individual's communication training or interventions resulting in goals that became stagnant over time due to lack of progress to the individual. An additional data collection sheet was developed since the baseline that focuses on the presence and condition of the device, but this had not been implemented yet Monitoring did not cover the use of the AAC during all aspects of the person's daily life in and out of the home. There was no evidence of a process or policy that ensured augmentative equipment was monitored throughout all aspects of the individual's daily life. Validation checks were not built into the monitoring process and conducted by the plan's author. Therewas no process in place that provides for validation checks to ensure consistency across monitors.	

Recommendations:

1. Continue to expand the presence of common area AAC as well as the implementation of such devices. There are multiple opportunities for Communication training, especially during times of transition and day programming. Because of this, these areas should be integrated into the overall level of care.
2. Reassess all individuals who have decreased receptive and expressive language skills with the revised communication assessment. Once reassessed, goals should be developed by the SLP and followed monthly if indirect, and upon contact if services are direct.
3. Clarify the intent of the "annual" assessment by SLPs. At the time of the onsite tour, it was limited to those who received direct services (two individuals only) and to those who were provided equipment. There appeared to be some inconsistencies as to who would be included as needing an assessment or update on an annual basis.
4. Unless a strong and current comprehensive assessment has been completed, it is of concern that an individual with an update would be deemed to not require further assessment unless there was a change in his or her status. In the case that an update is completed, reference to the comprehensive assessment should be made in the update and the comprehensive assessment should not be purged until such time a new comprehensive assessment is completed.
5. Once direct treatment is concluded, expand integration of communication strategies and devices into the individual's daily life. Training of augmentative communication must occur throughout the day and not only during structured treatment sessions.
6. Work closely with Psychology so that individuals who have behavioral issues related to lack of communication are provided with collaborative services from Psychology and Speech Therapy.

7. Develop a monitoring system that will ensure not only the presence of the device but appropriate implementation and effectiveness of the device and/or program. Included as part of this system should be systematic and routine review of the components of the functional communication programs and staff utilization of AAC devices.
8. Ensure improved consistency of how communication abilities and effective strategies for staff to utilize to enhance or expand language are included in the PSP.
9. Develop staff training that will focus on active communication and how to enhance communicative effectiveness. Training should be provided at new employee orientation and as an annual refresher.
10. Ensure training programs are functional and directly linked to the acquisition of language and/or speech.
11. SLPs should be attending AAC courses in an effort to increase knowledge and to introduce diversity among the objectives provided to the individuals living at RSSLC.

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:** 1. RSSLC Plan of Improvement (POI) 5/17/10 2. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10 3. Documents that were reviewed included the annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, task analyses, and behavioral and functional assessments. All documents were reviewed in the context of the POI and Supplemental POI and included the following individuals: #8, #10, #16, #24, #25, #36, #44, #52, #60, #115, #149, #199, #212, #267, #271, #282, #302, #315, #318, #328, #340, #344, #346, #353, #363, #399, #405, #415, #424, #426, #437, #448, #452, #455, #465, #493, #501, #525, #535, #547, #548, #551, #569, #583, #597, #612, #613, #630, #634, #643, #678, #740, #756, #758, #760, #772, #779 and #794. 4. Examples of best work in relation to skill acquisition programming: Individuals #309 and #500 **People Interviewed:** 1. William Eckenroth, PhD – Director of Behavioral Services 2. Don Williams, PhD, BCBA – Contractual psychologist 3. Deborah Grossett, PhD, BCBA – Contractual Psychologist 4. Cynthia Fannin – Director of Education and Training 5. Carol Agu – QMRP Coordinator 6. Heather Blackwell – Director of Vocational Services 7. Jim North – Rights Protection Officer 8. Donald Pavliska – Competency Training and Development **Meetings Attended/Observations:** 1. Human Rights Committee meeting (10/28/2010) 2. Psychology Peer Review Committee meeting (10/25/2010) 3. Neches Morning Meeting (10/26/2010) 4. Observed training, active treatment, staff interaction and meals at the following residences: Leon, Neches, Sabine, San Antonio, San Jacinto (10/26/2010, 10/27/2010, 10/28/2010) 5. Observed training in campus workshops and vocational (10/28/2010)
	Facility Self-Assessment: The Facility indicated that no Provisions or components of Provisions of the SA were in substantial compliance. The Monitoring Team is in agreement with the Facility regarding the self-assessment, but has noted that effort has been made to enhance various areas relating to skill acquisition programs and the performance of the PSTs. Additional time will be required to determine if these efforts produce and maintain meaningful change.

	Summary of Monitor's Assessment: Observations during the site visit reflected that staff of all levels were often poorly prepared to conduct training. In dining rooms, staff were frequently observed to be unaware of teaching opportunities, did not intervene when undesired behaviors were displayed, were not aware of the specifics of skill acquisition programs, and failed to remove potentially hazardous materials. In many circumstances, staff actions indicated a general lack of skills relating to applied behavior analysis. For example, staff often failed to reinforce desired behavior. In other situations, the minimal interaction between staff and individuals inhibited the opportunities for teaching and intervention. The lack of skills in relation to applied behavior analysis and other formal teaching procedures also contributed to noted weaknesses in skill acquisition programs. The majority of skill acquisition programs involved good organization, the basic elements of sound data collection, and a logical approach to teaching a skill. Despite these strengths, there was no indication that attempts were being made to utilize formal practices associated with successful learning. For example, programs included only a limited number of trials and a subjective process for selecting reinforcers rather than identifying reinforcers through reinforcer and preference assessments. In addition, data collection did not include documentation of the type or frequency of reinforcement. Observation also reflected that staff had not been provided sufficient training on specific formal programs. Staff typically could locate individual programs and data sheets, but often demonstrated that they were uncomfortable or unsure about implementing the programs. The overall impression gained from observations and reviews regarding skill acquisition programs was that the majority of the staff at RSSLC want to provide meaningful services for the individuals living at the facility but have not been provided the skills and resources necessary to do so. **For Provision S.1:** The provision was determined not to be in compliance. The Facility had introduced various training and support resources for staff, but insufficient time had passed to allow for an assessment of progress. In two "best practice" examples provided by the Facility, all skill acquisition programs included specific instructions for training sessions, data collection and steps to address undesired behavior. **For Provision S.2:** The provision was determined not to be in compliance. Although some improvement was noted in task analysis, assessment of intelligence, adaptive ability, behavior and mental illness continue to impede effective teaching. **For Provision S.3:** The provision was determined not to be in compliance. Skill acquisition training requires formalization and community vocational opportunities need to be developed.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	The review process focused upon the records for 36 individuals, as well as observations of program implementation. Two additional individuals were selected by the Facility as being "best work" examples from the revised PSP process. Only two records were identified as "best work" examples as the revised PSP process has been in effect for only a brief amount of time. Due to the goal of strengthening a skill or behavior, effective skill acquisition development and implementation requires many of the same basic components as behavior support plans: Comprehensive assessment of skills and individual resources, the use of formal training methods that include adequate opportunities for training and high levels of reinforcement, an evidence-based and empirical approach to teaching, valid and reliable data collection, and a sound strategy for assessing progress. When one or more of these components are lacking, the ability to provide adequate habilitation services is severely compromised. At the time of the baseline visit, it was noted that skill acquisition programs included diverse strengths and weaknesses. The majority of programs did reflect reliance upon some form of task analysis. These programs also included efforts to include the majority of basic components of a teaching program, such as behavioral objectives, operational definitions, specific instructions and appropriate consequences. These basic components in many cases lacked the sophistication necessary to achieve the goal of the program. Some examples are provided below. • Teaching procedures were noted to include typographical errors, varying formatting and vague wording that interfered with staff implementation. • The majority of skill acquisition programs included 1 to 3 trials per day or less. • Reinforcement for successful trials typically involved verbal praise. • Consequences for incorrect trials typically included verbal or physical guidance. There was seldom any indication that assessments had determined such consequences would not reinforce poor cooperation. • Documentation typically involved recording the level of prompting required for success and an area for comments. Adequate data collection should include such elements as the provision of reinforcement, incorrect responses, refusal, and displays of undesired behavior. • All progress reports for skill acquisition programs included only tabular displays of data. Data should be presented in graphs that include a baseline and basic structural components. The Facility indicated during the current site visit that few changes had been implemented in the processes relating to skill acquisition programming until recently. Observations supported the appraisal by the Facility. The Facility did report, however,	N

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		that efforts had been initiated to substantially improve the assessment of personal skills and the development of skill acquisition programs. These efforts included the following steps: • The development of a training curriculum addressing the PSP process, skill assessment, task analysis and the development of skill acquisition programs. This training involved both lecture and applied practice of the skills being trained, as well as follow-up monitoring of acquired knowledge. • The successful training of all QMRPs and PST members using the new curriculum. • The initiation of a task analysis process to supplement the PALS. • The development and implementation of a system to monitor the ability of PSTs to successfully meet the expectations established by the new training and procedures. Due to the recent implementation of the new procedures, the Facility indicated that few individuals had been involved in a PSP utilizing these new procedures. Two best work examples were provided by the Facility. A review of these examples revealed the following. • A structured form of task analysis was used to assess the abilities in relation to all skill acquisition programs. • All skill acquisition programs included a formal chaining procedure including clear indication of when training was beginning, and consequences for successful and unsuccessful responses. • All skill acquisition programs included specific instructions for training sessions, data collection and steps to address undesired behavior. • Data collection forms that documented the performance of the individual being trained, consequences for responses and the level of prompt required. The two examples provided by the Facility reflected the potential for substantial improvement in the habilitation process. The completion of several more PSPs will be needed to determine the level of success the Facility will be able to obtain. In addition, information provided by the Facility indicated various weaknesses in the new procedures. For example the ongoing review of PST practices and skill acquisition training is informal and provided no formal sampling procedure, no standardized tool for monitoring PSTs and skill acquisition training, and was documented primarily in the form of email and memoranda. These issues will need to be addressed before the new system could be described a fully functional. Reviews of the records for 36 individuals, as well as observations of those and other individuals in a variety of settings reflected an inability to provide reasonable levels of	

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		individualized engagement or recognize individual habilitation and safety needs. • In the Neches dining room, the following situations were observed. o Although people with a history of pica were present, numerous food and non-food items were observed on the floor. o Individual #723 attempted to pour a beverage from the pitcher into his glass. Staff were aware that he had diabetic dietary restrictions, but could not describe his program for self-serving a beverage other than to state that he had difficulty because he could not see well. o Five of 13 individuals engaged in stereotypic behavior. No staff intervened or redirected the individuals. o Two individuals, #10 and #282, were observed to use fingers to keep food on utensils. Staff did not intervene and no adaptive equipment was available. • In the Sabine dining room, staff were observed to engage in little conversation with individuals or provide formal prompting or reinforcement. • In the San Antonio dining room, the following situations were observed. o Individuals who demonstrated substantial independence and communicative skills had their dietary needs read to serving staff by direct care staff. It was not clear why these individuals had not been taught to convey this information themselves. o Several individuals were observed being prompted to use napkins and utensils, but no reinforcement or formal prompting strategies were utilized. o Several individuals were observed drinking rapidly without interruption or redirection. • In the San Jacinto dining room, living room and other areas, the following situations were observed. o Staff were observed to perform tasks in a very perfunctory manner, with little casual interaction or conversation with individuals. • In the pica-safe workshop, although vocational training was being implemented, staff had not been informed about PBSPs for pica and had not been provided training on such programs. In addition to improve the PSP and habilitation training process, the Facility will need to substantially enhance overall active treatment in order to satisfy the requirements of the Settlement Agreement.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to	Record reviews revealed that for 36 of 36 individuals, documentation of annual assessments were available in the record. As reported in Provision K, as well as in Provision S1, substantial limitations were found in the assessment reports and procedures. In general, attempts by the Facility to assess personal skills relating to skill acquisition programs did reflect the use of a task analysis process to varying degrees.	N

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	community integration, in the areas of living, working, and engaging in leisure activities.	Assessments to measure intelligence and adaptive ability, however, were not implemented at the Facility and some individuals had not been tested in those areas for several years. In relation to other areas, such as behavior or mental illness, assessments typically involved anecdotal statements, narrative reports, and generic rating scales. While these approaches could produce correct findings, research has indicated that such strategies are often inaccurate and misleading. To ensure that findings are valid, it is necessary to conduct objective assessments that can corroborate the subjective or informal attempts at assessment. Record reviews at RSSLC did not reveal formal and objective attempts to corroborate informal and subjective assessments.	
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:	Due to the limitations noted in Provisions K4, K5, K6, K7 and K9, as well as in Provision S1, it was frequently not possible to determine if training programs addressed pertinent needs of the individual. Without accurate and comprehensive assessment, it is not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As a result it is probable that RSSLC does not possess a clear measure of each individual's strengths and needs, and cannot develop, monitor or revise training programs with accuracy. Observations and interviews with staff also reflected that skill acquisition programs were not implemented consistently as written. Teaching was often conducted in a haphazard manner in terms of schedule and teaching strategy. Cues, prompts and other elements of effective training were often not offered or were presented in an informal and inconsistent manner. Staff members were observed to be collecting data in some areas, such as the vocational workshops, but not in other areas, such as residences. As a result, there was little to suggest that the implementation of skill acquisition programs consistently resulted in meaningful changes in behavior or skill level.	N
	(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	Observations revealed the following issues involving skill acquisition program implementation. • The majority of training programs for individuals living at the Facility often lacked structure, being presented without clear steps or trials. • Although staff often offered general prompts in order to elicit cooperation in non-training circumstances, no examples of formal and consistent prompting or opportunity for practice was observed. • Data for skill acquisition programs were not graphed. • It was not clear from available progress notes that individuals had strengthened existing behaviors or developed new skills because of skill acquisition programs. • Areas in the homes were not free of objects that could be targeted by individuals with pica. • Individuals who engaged in stereotypic or ritualistic behaviors were not consistently	N

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		offered redirection or other intervention.	
	(b) Include to the degree practicable training opportunities in community settings.	During the baseline visit, 66 individuals were employed on campus, with 159 employed at workshops. At the time of the current site visit, campus employment had increased by four to 70, while workshop employment had increased by four to 163. No off-campus employment was reported by the Facility. During the six months prior to the baseline visit, an average of 301 individuals participated in community outings each month. During the six months prior to the current site visit, the monthly average of participants in community outings was 283. The Facility reported that a new data system for tracking community outings had been developed and implemented in September, 2010. The purpose of the data system was to track overall community access, as well as help to identify those individuals who were participating in community activities at a lower than expected frequency. A part of the data system was a community outing checklist that served as a reminder of required materials and resources, as well as provided a list of dietary, medical and behavioral needs of each person participating in a community trip. Access to community resources is an important part of a person's life, but access alone does not sufficiently address the responsibility to provide meaningful training and active treatment. It was reported by the Facility that attempts were made to conduct skill acquisition programs in the community. Training data, however, did not clearly reflect training that had been conducted in the community as opposed to training that had taken place on campus. Staff at RSSLC reported that personalized access to community is provided in a variety of ways. One outstanding example involved Individual #760 who expressed a desire to attend a Spanish-language church service in the community as such services were not available on campus. Within a week, a church in the community had been identified and preparations had been made for the individual to attend at least twice per month. In addition, efforts were initiated to expand on-campus religious activities to include Spanish-language services for those individuals who chose not to attend services in the community. The self-advocacy program at RSSLC provides a group of individuals with opportunities to participate in community activities as well as to learn decision-making skills. RSSLC Self-Advocates attended the statewide annual self-advocacy conference and there is a plan in place to assist them to become members of the Fort Bend County self-advocacy	N

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		group in the community.	

Recommendations:

1. The initiation of efforts to enhance skill acquisition programs is welcome. In order to ensure that these efforts produce measurable benefits, it is recommended that RSSLC develop standardized practices for sampling PST performance, skill acquisition program content, and the ability of staff to competently implement the skill acquisition programs.
2. It is recommended that the Facility act to ensure that all training programs reflect an empirical, behavior-analytic approach to teaching. This includes formal identification of preferences and reinforcers, the provision of training with sufficient frequency to make learning likely, and the use of data graphs to represent individual responding to training programs.
3. It is recommended that the Facility act to ensure that all staff are prepared to conduct formal and informal training, have access to the necessary resources and have been provided with sufficient training.
4. It is recommended that the Facility ensure that all necessary assessments are conducted with sufficient frequency to allow for useful integration into the PSP process. This includes the completion of intellectual, adaptive, behavior and mental illness assessments.
5. It is recommended that RSSLC aggressively act to develop and maintain community employment opportunities for individuals living at the Facility.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Richmond State Supported Living Center (RSSLC) Plan of Improvement (POI), dated 5/17/10 2. RSSLC Supplemental POI (SPOI), dated 7/6/10 3. RSSLC Report for Monitors, dated 9/27/10 4. Supporting Visions training curriculum 5. Obstacles Report State Supported Living Centers, dated October, 2010 6. Since January 1, 2010, a list of all individuals who have been referred for community placement by his or her PSTs, including name, date of recommendation and current residential status 7. Since January 1, 2010, a list of all individuals who have requested community placement, but have not been referred for placement 8. Since January 1, 2010, a list of all individuals who have been transferred to community settings, excluding those whose discharge may be classified as an "alternate discharge" 9. Since January 1, 2010, a list of all individuals who have been discharged pursuant to an alternative discharge 10. A current list of all alleged offenders committed to the facility following court-ordered evaluations 11. Since July 1, 2009, list of all individuals who have been assessed for placement including, date of assessment, and resulting recommendation(s) 12. For the last six (6) months, a list of all trainings/educational opportunities provided to individuals, families and LARs to enable them to make informed choices. 13. Since January 1, 2010, a list of all individuals who have had a Community Living Discharge Plan developed 14. RSSLC Provider Fair attendance sheets for 10/27/10 15. RSSLC Orientation/Pre-service Training curriculum 16. Personal Focus Assessment (PFA) for Individual #544 17. Personal Support Plans (PSPs) for six individuals: Individuals#174, #274, #455, #630, #665, #747 18. PSP Addenda and Discussion Notes for four Individuals: Individuals #370, #467, #547, #750 19. Community Living Discharge Plans (CLDP) for eight individuals: Individuals #143, #148, #446, #450, #469, #668, #681, #778 20. Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for eleven individuals: Individuals #38, #143, #198, #280, #446, #450, #469, #668, #681, #755, #778 **21.** Post-Move Monitoring Checklists for eight individuals: Individual #38, #198, #280. #446, #627, #668, #681, #755 **People Interviewed:** 1. Cynthia Newton, Transition Coordinator 2. Carol Agu, QMRP Consultant

	3. Terri Carter, Post Move Monitor 4. Joan Poenitzsch, Director of Quality Assurance 5. Jim North, Rights Protection Officer 6. Jane Purcell, Assistant Director of Programs 7. Cynthia Fannin, Education and Training Director 8. David Savage, Program Auditor/QMRP Trainer 9. Seven QMRPs and five Social Workers 10. MRA Community Access Service Coordinator (CASC) **Meetings Attended/Observations:** 3. PSPs for 2 individuals: Individuals #358, #747 4. PFA for Individual #544 5. Post Move-Monitoring Visits for 2 individuals: Individuals# 453, #639 6. CLDP for Individual #14
	Facility Self-Assessment: The Monitoring team reviewed the RSSLC POI and SPOI. The POI indicated that the DADS State Office Policy Unit would be responsible for the development of statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the SA. Overall, the Facility indicated it was not in full compliance with any of the provisions of Section T, and the monitoring team concurred with one exception. The Facility indicated it was not in compliance with component T1h, the issuance of the Community Placement Report at required six month intervals. The monitoring team found that the Facility did collect all the required information and had assimilated it into the required report, although it provided two different versions. Overall, the Facility would appear to be in substantial compliance with this component.
	Summary of Monitor's Assessment: The monitoring team reviewed a sample of documents in each of the provisions order to be able to assess progress, if any, from the baseline tour and provide any additional recommendations that may be helpful to the Facility as it undertakes action in these provisions. The findings are as follows: **Provision T1:** This provision was determined to be not in compliance. This was generally consistent with the Facility's self-assessment. RSSLC had undertaken a number of initiatives that were intended, at least in part, to assist PSTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs. Included among those was the implementation of the new statewide PSP process on October 1, 2010. New statewide policies had been issued in conjunction with the roll-out of the statewide PSP process, but these were not yet incorporated into Facility policies and procedures. Since the last monitoring visit, RSSLC had engaged in some educational activities about available community placements to individuals and their families or guardians to enable them to make informed

	choices, and 13 individuals had transitioned to community living. While the CLOIP continued to be the primary vehicle for providing information about community living options to individuals, LARs and family members, on two occasions it was noted that individuals visited friends in the community. The monitoring team commends the Facility for encouraging this type of awareness activity, as it allows individuals to maintain relationships while also gaining a better understanding of how community living might be relevant to their own lives. Observations and document reviews during the monitoring visit indicated the Facility continued to need improvement in the areas of interdisciplinary assessment, individualized assessment of need for supports and services in the most integrated setting, and development of individualized strategies for education about community living options to promote informed choice. The new PSP process did appear to succeed in focusing the PST on preferences of the individuals and how action plans might be developed to support those preferences, but these tended to lack a guiding vision and to be superficial in focus. The monitoring team met with a group of representative QMRPs and Social Workers and found them to be both thoughtful and enthusiastic about the implementation of this new process, which should be seen as a real strength for the Facility. The Facility had made substantial improvements to its processes for transition and discharge planning, but the assessment of needs for supports and services still failed to adequately capture significant health and safety information that would be needed to ensure a successful transition. On a very positive note, for individuals who had been referred for transition, the Facility had begun to make documentation of provider search activities, including the trial visits individuals made and their reactions to these through PSP Addendum meetings. DADS had issued its first annual Obstacles Report for the State Supported Living Centers in October, 2010, which provided guidance to the Centers as to the methodology and categories of obstacles to be used in order to ensure the State Office receives comparable data from each one. The monitoring team found the report to provide excellent guidance to the Facility regarding the types of obstacle data to be collected, such that it may be collated and provide an accurate picture of the obstacles to be addressed both in the catchment areas and the state as a whole. This will, of course, be dependent on how well the PSTs can accurately identify the obstacles. Ongoing PSP observation and mentoring of team members was expected by the Facility to improve the PSTs' capacities in this regard, but additional specific training would also seem to be called for. In terms of methodology, the process described continues to rely heavily, as appropriate, on the PSTs to identify the obstacles on an individualized basis for each person, but the PSTs at the Facility were not skilled in making such assessments. **Provision T2:** This provision was determined to be not in compliance. The monitoring team found that the Post-Move Monitor was diligent and effective in her efforts. PMM Checklists were being completed in a timely manner. There were some instances in which the Post-Move Monitor did not adequately document the presence of supports, or follow up on an item to close the loop and document the resolution of the concern or need. This was seen, on occasion, in both document review and during the on-site PMM visits.

	Provision T3: This provision does not require a compliance review as it merely acknowledges that certain individuals who are at the Facility for court-ordered evaluations are exempt from the provisions of Section T. **Provision T4:** This provision was determined to be not in compliance. The Facility acknowledged in the POI a need to have policy and procedure that defined how it would identify and implement alternate discharges consistent with CMS-required discharge planning procedures, rather than the provisions of Section T1d, and T1e, and T.2, for the individuals who are classified in the SA as alternate discharges. Such alternate discharges could occur at any point, and the Facility should have policies and procedures in place to define its processes. Its plan, according to the POI, was to update its local policy and procedure once anticipated updates to the statewide policy on Most Integrated Setting wee provided.

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T1	**Planning for Movement, Transition, and Discharge**	This provision was found to be not in compliance.	N
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.	This component was found to be not in compliance. The Facility's current population was 397. Thirteen individuals were reported to have transitioned to the community since the baseline visit in April, 2010, including one person who transitioned during the week of this October site visit. No individuals had returned from an unsuccessful placement during this time. Statewide policies and procedures for Personal Support Planning had been issued that may have a significant impact on the consideration of the most integrated setting. These had not yet been incorporated into the Facility's local policies and procedures. New procedures, forms and/or instructions related to the CLDP and PMM are also pending final issuance by DADS State Office. It was reported that no changes or updates had been made to any MRA policies, procedures or other materials related to community living, transition and discharge. RSSLC had undertaken a number of initiatives that were intended, at least in part, to assist PSTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs. • RSSLC had recently implemented the new statewide PSP process. Training in the new Supporting Visions curriculum had been ongoing at the Facility since 9/3/10. According to the Report to Monitors provided at the entrance meeting, 426 staff had been trained in the new process. It remains to be seen whether this new process will result in any enhancement to the ability of PSTs to assess	N

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		the supports and services needed by individuals in the most integrated setting. The QMRP Coordinator and QMRP Trainer had been providing coaching and training, including mock PSP and PFA meetings and development of facilitator skills. • The Facility had also begun monitoring the PSP process. See Provision F2g for additional detail. • The Director of Social Services functions were divided to allow for a full-time position to be dedicated to transition coordination, as reported in the entrance conference. This was not yet formalized by a change in the job description for the positions. • In August, the Facility held a joint meeting of QMRPs and Social Workers to begin to develop strategies for enhancing the comfort of families and LARs with the process of the Community Living Options Discussion These are positive steps, but none of these initiatives had been implemented long enough to be able to adequately assess their eventual impacts on compliance with the overall requirements of this component. As detailed in the rest of this Section T and in Section F above, outcomes in the areas of assessment and planning for protections, services and supports; education for community awareness;, transition and discharge planning; and post-move monitoring indicated the Facility could not be said to be effectively assisting and encouraging individuals to move to the most integrated setting yet.	
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:	This component was found to be not in compliance. New statewide policies had been issued in conjunction with the roll-out of the statewide PSP process, but these were not yet incorporated into Facility policies and procedures. To assess progress and compliance in this area, the monitoring team attended two PSP meetings, reviewed another five PSPs that were developed under the new PSP format, and attended one PFA meeting. The monitoring team also reviewed the curriculum for the Supporting Visions PSP training and the supporting statewide policy and procedure. New statewide policies and processes around the CLDP and PMM were also on the verge of being rolled out. All of these processes were very new or not yet completely implemented. The monitoring team therefore reviewed these components with an understanding that it will take some time for them to mature and be ready for a thorough evaluation as it relates to compliance.	N
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety	The new PSP process was predicated on beginning with a vision for the individual as the basis for identifying the supports and services 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. This vision was intended to be developed through the Personal Focus Assessment (PFA), completed by the individual, family and PST during	N

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	and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	the third quarter preceding the annual PSP. This revised PFA had not yet been implemented to an extent that would allow for it to be assessed. The monitoring team looks forward to observing this process as it moves forward. A note of caution should be sounded, however, as to whether the PFA should or could be seen as a singular vehicle for envisioning an individual's future, or preparing an individual to participate in his or her own planning in a meaningful way. Individuals with intellectual disabilities may benefit from repeated and ongoing experiential activities as opposed to once or twice a year. As described in Section F1b, individuals were not always supported to participate in a meaningful or appropriate way during this monitoring visit. The State and Facility should consider how it might expand on the PFA process to be an ongoing process that truly supports individuals to be active participants in their own planning. The ability and skill of the PST in assessing and recommending protections, supports and services needed in the most integrated setting relies on their ability and skill to complete these same assessments in the current setting at the Facility. As described in some detail throughout Section F above, the PSTs were not proficient in these areas. This was affirmed in the review of the PSP process for Section T. The new process, as observed in two PSPs during the site visit and in the documentation for five PSPs completed using the new process, did appear to succeed in focusing the PST on preferences of the individuals and how action plans might be developed to support those preferences. However, the PSTs had a tendency to focus on food and activity preferences that would fall short of qualifying as a vision for an individual's future. For example, for Individual #358, much of the emphasis of the meeting centered on her preferences for Coke and Coke memorabilia. DADS and the Facility will need to guard against the PSP becoming superficial in its focus. With that said, the two PSPs attended for review of this Section T still seemed likely to result in more focus on an individual's preferences. The LAR for Individual #358 indicated in an interview following the PSP meeting that this was an improved process, simply for the fact that so many more people attended than was usual. The monitoring team was concerned that the new PSP process appeared to have an unintended effect of curtailing the discussion of community living options and obstacles thereto, as these were minimally addressed in the two observed PSPs and the sample of five of the new format that were reviewed. The PSTs typically began the PSPs with a discussion of the individuals' preferences for such things as certain daily routines and food items, but these were not typically discussed in the context of a vision for the individuals' future lifestyle. In the observation of two PSPs, the teams were not able to integrate the discussion of personal preferences with a broader vision of lifestyle in the most integrated setting. The Supporting Visions video that was in use for the newly implemented training may have created a certain level of misunderstanding of the	

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		process, as its focus was on individual preferences, rather than on how individual preferences would fit into a comprehensive vision for the individual's future. The take-away message seemed to be that a plan was to be created around personal preferences that would then be appropriate *regardless* of where the individual lived, which may have had some causative effect in the diminished attention to community living options and potential obstacles. It was also not clear the PSTs had received specific instruction as to their responsibility to provide their professional assessment of an individual's most integrated setting in relation to the requirements of ADA and Olmstead, as described in F1e above, and the PSTs often failed to provide such a professional assessment of the most integrated setting appropriate to an individual's needs and preferences. This responsibility was not adequately addressed in the reviewed Supporting Visions training curriculum. Based on these findings, the monitoring team recommends that the Supporting Visions curriculum be expanded and/or supplemented to train teams to better integrate the identification of personal preferences with a more comprehensive vision of a future lifestyle, as well as to assess how this vision could be supported in the most integrated setting. In terms of obstacles, the monitoring team did observe in one PSP, for Individual #747, a PST attempt to address LAR opposition by suggesting that the LAR and individual tour the apartments on the Facility grounds and perhaps consider having the individual move to that setting as a means of increasing awareness. Otherwise, the PSPs reviewed and observed did not adequately address the most integrated setting; protections, services and supports needed in that setting, or obstacles to be addressed.	
	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.	Since the last monitoring visit, RSSLC had engaged in some educational activities about available community placements to individuals and their families or guardians to enable them to make informed choices. • The CLOIP continued to be the primary vehicle for providing information about community living options to individuals, LARs and family members. Since the last monitoring visit, 210 individuals and their families and LARs had been contacted by a CASC in advance of the annual PSP. • There had also been 15 CLOIP community tours since the last monitoring visit in April, 2010. A total of 114 individuals had attended these community tours, with a few individuals attending more than once. • A 2 ½ hour Provider Fair was held on 10/27/10, during the monitoring site visit. It was attended by 60 individuals, 39 providers, 72 RSSLC staff and ten family members/friends. The number of individuals attending the brief Provider Fair represented approximately 15% of the population of those living at the Facility. For five of six individuals who had requested community placement, but had not been referred, attendance at the Provider Fair was not documented, even though	N

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		four of the five had PSP that indicated they would be provided with opportunities to enhance their awareness. • On two occasions, it was noted that individuals visited friends in the community. The monitoring team commends the Facility for encouraging this type of awareness activity, as it allows individuals to maintain relationships while also gaining a better understanding of how community living might be relevant to their own lives. The Facility had not taken full advantage of other potential opportunities for providing education and increasing awareness about community placement. For example, the Facility reported that there had been no revisions or additions to any facility or MRA staff training curricula or materials related to community living, transition and discharge since the previous site visit. In addition, a review of the Facility's Orientation and Pre-Service curriculum indicated that no time was devoted to community living options. There was a 2 hour segment devoted to Person-Directed Plans, but the curriculum material provided did not specifically address community living options or most integrated setting. On a very positive note, for individuals who had been referred for transition, the Facility had begun to make documentation of provider search activities, including the trial visits individuals made and their reactions to these through PSP Addendum meetings. For example, for Individual #547, the PST documented contacts with four providers before locating one which the individual was interested in visiting. For Individual #467, the PST documented the pros and cons of four homes related to the individual's specific needs and preferences.	
	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	RSSLC reported that the Community Living Options Discussion during the PSP served as the assessment for placement. The Facility provided a list of 113 individuals who had been assessed for placement since 7/1/10, using this definition. From observations and document reviews as described in F1e, T1a and T1b above, the Community Living Options discussion was not implemented in such a manner that it could yet be considered an effective assessment for placement. In some respects, the new statewide PSP process seems to have curtailed that discussion rather than enhanced it. A number of improvements should be made to how the process is implemented before the facility begins to consider that individuals have been truly assessed for placement.	N

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	policies, procedures, and practices.		
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	This component was found to be not in compliance. To assess this component, the monitoring team reviewed documentation of referrals for transition and actual transition dates, reviewed CLDPs and the accompanying assessment information, and reviewed the documentation of verification that the community provider was prepared to meet the individuals' needs prior to transition. The monitoring team also reviewed the existing record and attended the CLDP meeting for one individual while on site. DADS' policy requires that placement occur within 180 days of referral in order to be considered timely. RSSLC provided a list of 29 individuals who had been referred for community placement since 1/1/10. The 180 day window was completed for 17 of these individuals, as their referral date occurred prior to 4/29/10 (180 days prior to this compliance visit). For this group of individuals, the number of days from referral to placement ranged from 12 to 227. The average time was approximately 136 days. For four of 17 referrals, the time from referral to placement exceeded 180 days; no documentation of extensions was provided. Other findings for T1c follow.	N
	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.	For seven of eight CLDPs reviewed and for the one CLDP held during the monitoring visit the listing of essential and essential supports did not adequately capture basic requirements for a successful transition. In many instances boilerplate phrases were being used, such as requiring "PCP, staff knowledgeable of medical needs/condition," but these did not always provide sufficient specific and individualized information to ensure health, safety and quality of life. The essential and non essential supports section also informs the development of the PMM Checklist; if it is not specific, then it is likely things will fall through the cracks. The following examples are not an exhaustive list, as many more were found in brief review process. • For Individual #143, on page 13 of the CLDP, it stated that staff should be aware of the need to avoid ibuprofen and acetaminophen due to chronic kidney disease. On page 11, the CLDP states that the individual is allergic to chocolate, but is fond of chocolate milk and will need supports in place to ensure she does not consume this beverage. Neither of these was specifically carried forward as information for staff to be inserviced on as essential supports. Instead, the CLDP requested, as a nonessential support, that the Primary Care Provider (PCP) make a determination about these needs, within 30 days after the move. Given that current information was that these substances would be harmful to the individual's health, the CLDP should have specifically ensured that community staff were trained as such until any new information could be obtained. • For Individual #198, the CLDP noted on page 6 that the individual needed stand-by assistance on uneven surfaces. This was not carried over specifically to the	N

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		essential supports; instead it stated that staff would be "provided training of needs, preferences, etc." • For Individual #450, on page seven of the CLDP, it states that the individual should avoid nephrotoxic drugs, NSAIDs, etc, and that the individual was currently using a gait belt, knee pads and rolling walker. Fall prevention processes were recommended. None of these were specifically documented in the essential and nonessential supports section. • For Individual #469, the PST failed to identify important information that existed in an audiological assessment, including bilateral hearing impairment and certain recommended communication strategies. (see T1d below for details). The audiological assessment recommended strategies such as standing within six-eight feet speaking range, gaining the individual's attention before attempting communication and reducing background noise whenever possible. The CLDP did not incorporate any of these strategies. • For Individual #14, whose CLDP was held during the monitoring visit, the PST failed to identify the need for careful monitoring following transition as follow-up to the left temporal mastoidectomy and lipoma resection completed in 2004. The PST was unaware of the strong potential for the underlying condition to recur and the potential risk for mortality should it do so. The PST did not make any recommendation for such follow-up. When the monitoring team brought it to the team's attention, the PST was unable to address it because the physician was not present at the CLDP meeting. It was noted that the physician did appear at the meeting for a few moments earlier in the meeting, signed the attendance sheet and then asked to be excused to attend to other duties. In addition, the individual had been adjudicated incompetent in the past, but guardianship had lapsed and no successor guardian had been identified. The community provider needed to be aware of this in the event decisions needed to be made, and the PST should have included the development of a plan for this need in the essential and nonessential supports section. The CLDP process is a continuation of the Facility's responsibility to assess the needs of an individual who will be moving to a more integrated community setting, and to ensure that the community setting adequately meets those needs. The identification of essential and non-essential supports must begin by considering those things identified in the PSP. The potential problem with this was that it was not clear the PSTs were proficient in overall needs assessment, the interdisciplinary process necessary to integrate the assessment findings into a comprehensive support plan, or finally, the identification during the PSP planning meeting of the supports and services needed and desired in a community setting, as also described in Section T1b.	
	2. Specify the Facility staff	For eight of eight CLDPs reviewed using the existing processes, RSSLC did not always	N

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	responsible for these actions, and the timeframes in which such actions are to be completed.	assign specific Facility staff responsibility for all essential and non-essential supports. Instead, staff from the selected provider were identified rather than Facility staff. It was not clearly stated that Facility staff had any responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness. Facility policy and procedure should specify the expectations in this regard, that CLDPs should assign responsibility to Facility staff to ensure that all required activities are completed, even if a provider or MRA staff has primary responsibility for the activity.	
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	For three of the eight CLDPs reviewed, it was not apparent that the plans were reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting, as evidenced by the lack of signatures and specific documentation of participation in the meeting minutes for these parties. For the one CLDP attended during the monitoring visit, the individual did not attend, although attempts were made to have him participate. The Facility should develop strategies to ensure that individuals are provided with information related to the CLDP in the manner that best suits their needs, whether this occurs at the CLDP meeting or in other settings that better meet individual needs.	N
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.	This component was found to be not in compliance. While the Facility has made improvements to this component, it indicated that it was not yet in compliance. For eight of the eight CLDPs reviewed using the existing processes, some of these improvements were observed. The comprehensive assessment was reported to have been reviewed either at a previous date or at the CLDP meeting, and in all instances this review was reported to have been completed within 45 days prior to the individuals' move date. The CLDP document included both the assessments that were being reviewed and, in most cases, a summary of the assessments and the discussion surrounding them. It was not always clear that the process of reviewing the assessments was sufficiently thorough enough to capture important information, much as was found in the interdisciplinary consideration of assessments in the PSP process as a whole as described in Section F1d. For example: • For Individual #469, there was an audiological assessment on 10/27/09 that found moderate deficits in both ears through the basic speech frequencies, and recommendations were made for implementing communication strategies such as standing within six-eight feet speaking range, gaining the individual's attention before attempting communication and reducing background noise whenever possible. The speech evaluation used during the same review process was dated 9/28/09 and stated the individual had no hearing impairment. It further indicated the clinician attempted standardized assessments, but that no	N

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		data was collected due to the individual's inability to attend to the task presented. One would have to ask whether the clinician's apparent lack of awareness of the individual's hearing impairment may have affected the administration of the assessments or the perception of the individual's "inability" to attend to the task. For the purposes of the CLDP, this apparent conflict was not identified or addressed, leaving a possible situation in which the community provider may yet be unaware of the individual's hearing impairment and needed accommodations. • For the CLDP for Individual #14 observed during the monitoring visit, a similar situation occurred. The individual's record indicated a potentially life-threatening condition that had been treated, but had a relatively high probability of recurrence (see T1c1 above for details.) The PST had not been aware of this nor addressed it at the CLDP.	
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.	This component was found to be not in compliance. The monitoring team requested and received documentation of the MRA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for 11 individuals who had transitioned to the community since 5/17/10. These generally appeared to have been completed in a timely manner following the CLDP and prior to the actual transition date, per the completion date, with the following exceptions. • It was noted that the first item on the instrument called for the MRA to verify through the DADS Quality Reporting System (QRS) that the provider was in good standing during the week in which the pre-site visit was made, and to print and attach the verification paperwork. For 11 of the 11 instruments, this item was checked yes, but all of the verifications provided as evidence indicated that the last update of the information on the QRS website was 10/07/2010. This would appear to suggest that all were printed after that date, so it is not clear the Facility had the verification documents in their files prior to that date or that they were printed within the week of the pre-move site visits, which ranged from 5/20/10-10/20/10. None of these pre-move site visits occurred within the week prior to 10/10/2010. • For individual #38, the MRA had not completed the pre-move site visit as of 2 days prior to the scheduled transition date. The Facility completed the visit and review on the day before the move, after noting that the "MRA called the day before and wanted to delay move." Because the individual did not want to delay, the Facility completed the review, which was commendable; however, the Facility should have already been aware the pre-move site visit had not been	N

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		completed at that late dat,e and should have taken action to obtain the verification well before two days before the scheduled move. The current process and form did not lend itself to ensuring the presence of supports and services. For 11 of the 11 MRA Continuity of Care instruments, there was no documentation as to whether specific essential or non-essential supports were in place, nor any plans for the implementation of any non-essential supports that would be required for the Facility to have in place prior to the individual's departure from the Facility. For three of the 11 reviewed, the instrument and/or process in use were not complete or did not otherwise provide adequate information as to the readiness of the provider to meet the individual's needs. Examples included: • For Individual #755, for the question "Did the site administrator/manager verify services and supports could be provided that are necessary to assist the consumer in achieving the outcomes?" the MRA staff did not check any of the applicable boxes. • For Individual #778, for the question "Per the site Administrator/Manager – Does the setting present any environmental concerns that would impact the consumer's identified needs?" the MRA Continuity of Care instrument was checked yes, but no additional details were provided as to the nature of the concerns, nor how they had been or would be remedied. • For Individual #668, the MRA Continuity of Care instrument indicated MRA staff had verified on the QRS that the provider was in good standing, and a copy was attached. The QRS form indicated that just over a month prior to the transition date, the provider was cited because it failed to ensure that a program participant experienced residential relocation in a planned manner. The QRS form indicated that the provider was required to submit a corrective action plan, but that no follow-up visit was required. There was no documentation as to how the very recent deficiency might have impacted the transition for Individual #668, nor follow-up by the Facility or MRA to ensure the corrective action plan had been implemented. The Facility was aware that this process did not satisfy all the requirements for ensuring supports and services were in place. The Transition Director reported that a new CLDP process was to be implemented in the near future that would call for the Facility to verify for itself, rather than relying solely on the MRA Continuity of Care visit, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety are in place at the	

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		transitioning individual's new home before the individual's departure from the Facility, and that a plan for the implementation of all nonessential supports was obtained prior to the individual's departure.	
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.	This component was found to be not in compliance. The Transition Director and Director of Quality Assurance both reported that the Facility had not yet developed or implemented 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. The Facility should consider ensuring the integration of the PSP quality assurance processes with the CLDP quality assurance as it is developed, as the PSP assessments and identification of needed protections, services and supports form the foundation for the CLDP identification of same. In addition, the Facility should consider how it will measure and assure timeliness across the transition planning process.	N
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	This component was found to be not in compliance. The Facility did not provide any documentation that it gathered and analyzed obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. It is expected that the Facility will gather obstacle data on a comprehensive basis, perform some type of analysis or interpretation of the data (i.e., a comprehensive assessment), such as a narrative in which they can provide more depth to the straight numbers, and provide that information to DADS on an annual basis. The analysis should be predicated on a consistent methodology for collecting information that is described at the outset of the report. DADS had issued its first annual Obstacles Report for the State Supported Living Centers in October 2010, which provided guidance to the Centers as to the methodology and categories of obstacles to be used in order to ensure the State Office receives comparable and consistent data from each one. The monitoring team found the report to provide excellent guidance to the Facility regarding the types of obstacle data to be collected, such that they may be collated to provide an accurate picture of the obstacles to be addressed both in the catchment areas and the state as a whole. In terms of methodology, the process continued to rely heavily, as appropriate, on the PSTs to identify the obstacles on an individualized basis for each person. It also referenced the newly revised PSP process that was currently being introduced to the facilities, and stated that specific direction would be given to the PSTs under this new process to address the content of the Living Options discussion to include both the individual's and his/her LARs awareness, experience, and exposure to alternate living	N

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	be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	arrangements. The revised process was also described as including "a Personal Focus Assessment that will provide the PST with the individual's interest in pursuing alternate community placement, along with a geographic location for possible future placement, prior to the annual planning meeting. This will provide the PSTs with three months to explore the identified geographic location for obstacle identification prior to the Living Options discussion at the annual PST meeting." Given that the Living Options discussion seemed to have been less of a focus under the new PSP process, the PSTs will need considerable clarification and further training to adequately perform these tasks that form the basis for obstacle identification. The QMRP Trainer, who had been designated responsibility for the future development of the Facility obstacle report at RSSLC, stated during interview that the PSTs were not yet doing an adequate job of identifying the obstacles, which would bolster the impression that additional training is needed. He indicated that ongoing PSP observation and mentoring of team members was expected to improve the PSTs' capacities in this regard, but additional specific training would also seem to be called for.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community	RSSLC provided two different documents entitled Community Placement Report, one dated 12/1/09-5/31/10 and one dated 12/1/09-10/7/10. The Transition Coordinator stated that the latter report was the official document. It included the names of 49 individuals, the date referred, the date closed and the reason closed. Of these referrals, four were reported closed due to LAR or family choice.	SC

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	services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**	This provision was found to be not in compliance.	N
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	This component was found to be not in compliance. The monitoring team found that the Post-Move Monitor was generally diligent and attentive in her efforts. PMM Checklists were being completed in a timely manner. There were instances in which the Post-Move Monitor failed to document carefully and/or follow up as needed. For seven of eight PMM Checklists of individuals being monitored, there were instances of a lack of documentation or needed follow-up by the Post-Move Monitor. Examples included: • For Individual #280, the PMM Checklist for the 7-Day visit on 9/10/10 failed to document whether certain essential and nonessential supports were present. The essential supports section regarding safety included requirements as to the provision of adaptive equipment by RSSLC and staff training on the use of this equipment. The presence of these supports was not documented. • For Individual #198, nonessential supports included participation in community integration activities. The PMM Checklist for the 7-Day, 45-Day and 90-Day visits all were checked as present for this item, but the only evidence provided on all three Checklists was a single visit to the park and a fireworks show on 7/05/10, which occurred approximately one week after the date of the transition. • Similarly, for Individual #668, the nonessential supports included participation in community integration activities. The PMM Checklist for the 7-Day, 45-Day and 90-Day visits all were checked as present for this item, but the only evidence provided on all three Checklists was a note that indicated the individual went to the park on Thursday. • For Individual #755, the nonessentials indicated that a Department of Assistive	N

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		and Rehabilitative Services DARS referral was due on 9/15/10. The item was not checked as to whether it was present or not, nor was there any notation provided as to a plan for implementation.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The evidence for this component was insufficient to substantiate compliance, particularly given the findings in section T2a above in terms of the PMM process. PMM visits documented in T2a indicated that there are some concerns as to the thoroughness of follow-up activity required to ensure resolution of potential problems. In order to substantiate actual compliance with this component, additional PMM visits will need to be observed. The monitoring team accompanied the Post-Move Monitor on one 7-day and one 45-day monitoring visit for two individuals who had moved to the community from Austin SSLC. In preparation, the CLDPs and any previous Post-Move Monitoring Checklists for each of the individuals were also reviewed. The Post-Move Monitoring Checklist was used to guide the reviews. As noted during the baseline visit, the Post-Move Monitor at RSSLC was both diligent and thorough in her approach to the PMM visits made during this site visit. There were occasional instances, in two of two PMM visits, in which the Post-Move Monitor should have been more thorough in her approach, however. Examples included: • For Individual#639, the Post-Move Monitor had not yet been in contact with the individual's school setting, although she noted that the only adjustment problems the individual seemed to be experiencing were in the school. The Post-Move Monitor was relying on the report of the foster family to gauge adjustment. While it is recognized that a child may not want an adult to come to the school, a telephone contact could be expected to provide the necessary information on a more first-hand basis. The CLDP for the individual also noted on a number of occasions the importance of maintaining the relationship between the individual and grandparent. This was not carried over to the PMM Checklist, nor did the Post-Move Monitor address this until prompted by the monitoring team. The Post-Move Monitor inquired of the individual as to the individual's satisfaction and happiness with the home, but did so in front of the foster family. Many individuals would be reluctant to express dissatisfaction under such circumstances, especially a child, and it was recommended to the Post-Move Monitor that this question be asked in a more private way in the future. • For Individual #453, the essential supports required the development and routine use of a picture schedule. The picture schedule was seen in the individual's room, but it was apparent on inspection, by its random disarray that it had not been used in systematic way during the day of the visit. The Post-	N

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		Move Monitor did not question the provider about this, but later acknowledged she had noticed it had not apparently been in use.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	RSSLC stated that it had no alleged offenders committed to the facility. This provision does not require a compliance review as it merely acknowledges that certain individuals who are at the Facility for court-ordered evaluations are exempt from the provisions of Section T.	
T4	**Alternate Discharges -**	This provision was found to be not in compliance.	N
	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;	The Facility reported no alternate discharges had taken place since the last monitoring visit. The Facility did not have policy and procedure that defined how it would identify and implement alternate discharges consistent with CMS-required discharge planning procedures, rather than the provisions of Section T.1 (d), and (e), and T.2, for the individuals who are classified in the SA as alternate discharges. Such alternate discharges could occur at any point, and the Facility should have policies and procedures in place to define its processes. In the POI, the self-prescribed Action Step required the SSLC to develop policies/procedures governing most integrated setting that include all SO requirements and additional facility specific requirements. At a minimum, it was expected the SSLC policy/procedure would address all the components for CMS required discharge procedures as described in the SA. The Facility indicated it planned to update its local discharge policy and procedure upon anticipated statewide policy updates.	N

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	(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.		

Recommendations:

1. The Action Steps listed in some portions of the POI were based on achieving 100% compliance in record reviews; however, the requirements of some components would not seem to lend themselves to record reviews, even for the purpose of providing evidence of compliance, much less as a plan for achieving compliance. The Facility and DADS may want to review the evidence it deems necessary to establish actual compliance.
2. The new PSP process, as implemented during this site visit, seemed likely to result in more focus on an individual's preferences but concentrated on preferences for food and activities without discussion of a vision for the individual's future. DADS and the Facility will need to guard against the PSP becoming superficial in its focus. The Facility and DADS should consider whether the Supporting Visions curriculum should be expanded and/or supplemented to train teams to better integrate the identification of personal preferences with a more comprehensive vision of a future lifestyle, as well as to assess how this vision could be supported in the most integrated setting.
3. Discussion of community living options and obstacles thereto needs to be robust. The State and Facility need to ensure that the new PSP process retains or improves on the level of discussion about community living options, obstacles, and supports to overcome obstacles.
4. The Facility should develop a comprehensive strategic plan for education and awareness about community living options, with clear goals, assigned responsibilities, timelines and outcome measures. The Facility should take full advantage of the variety of potential opportunities for providing education and increasing awareness about community placement, including, but not limited to, increased community tours; new employee orientation and ongoing training to ensure PST members are prepared to assist individuals, families and LARs to make informed decisions, and self-advocacy activities.
5. The revised PFA had not yet been implemented to an extent that would allow for it to be assessed. The Facility should consider whether the PFA should or could be seen as a singular vehicle for envisioning an individual's future, or preparing an individual to participate in his or her won planning in a meaningful way. The State and Facility should consider how it might expand on the PFA process to be an ongoing process that truly supports individuals to be active participants in their own planning.
6. Facility policy and procedure should specify the expectations for CLDPs to clearly state the responsibilities that Facility staff have to provide supports, monitor, and follow up with the designated provider staff to ensure implementation and/or timeliness for all essential and nonessential supports.
7. The Facility should develop strategies to ensure that individuals are provided with information related to the CLDP in the manner that best suits their needs, whether this occurs at the CLDP meeting or in other settings that better meet individual needs.
8. The Facility should consider ensuring the integration of the PSP quality assurance processes with the CLDP quality assurance process as this process is developed. As part of quality assurance, the Facility should consider how it will measure and assure timeliness across the transition

planning process.

9. In terms of methodology, the process the Facility will need to implement to inform the development of the statewide Obstacles Report continues to rely heavily, as appropriate, on the PSTs to identify the obstacles on an individualized basis for each person. Given that the Living Options discussion seemed to have been less of a focus thus far under the new PSP process, the PSTs will need considerable clarification and further training to adequately perform the tasks that form the basis for obstacle identification.
10. Since alternate discharges could occur at any point, the Facility should develop and implement policy and procedure that defines how it would identify and implement alternate discharges consistent with CMS-required discharge planning procedures, rather than the provisions of Section T.1I,(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.

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Richmond State Supported Living Center (RSSLC) Plan of Improvement (POI), dated 5/17/10 2. RSSLC Supplemental Plan of Improvement (SPOI), dated 7/6/10 3. RSSLC Report for Monitors, dated 9/27/10 4. Prioritized list of 226 individuals who either have a Legally Authorized Representative (LAR) or have been identified as being in need of an LAR 5. List of 6 individuals for whom an LAR has been obtained since 1/1/10 6. DADS draft Policy Number: 019 Rights and Protection (including Consent & Guardianship) 7. Rights Assessments for 14 individuals: Individuals #264, #271, #330, #390, #448, #467, #512, #547, #630, #729, #747, #750, #773, #780 **People Interviewed:** 1. Cynthia Newton, Transition Coordinator 2. Jim North, Rights Protection Officer 3. Joan Poenitzsch, Director of Quality Assurance 4. Robin Eversole, Community Relations Office **Meeting Attended/Observations:** 1. PSPs for 2 individuals: Individuals #358, #747
	Facility Self-Assessment: The Monitoring team reviewed the RSSLC POI and SPOI. The POI indicated that the DADS State Office Policy Unit will be responsible for the development of statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the SA. A draft policy, Policy Number: 019 Rights and Protection (including Consent & Guardianship), had been promulgated and was under review at the time of the monitoring site visit. The POI stated that Facility policies, procedures and practices in this area would be developed following the final issuance of the statewide policy. The SPOI listed some of the actions the Facility had taken or was planning to take to address recommendations made at the time of the last monitoring visit, including that the Transition Coordinator had sent letters inquiring about obstacles LARs experience in renewing guardianship and received some 20 responses that indicated at least 2 months notice was needed to renew guardianship. In response, a policy was being drafted to include that letters to LAR's concerning guardianship would be sent out 3 months in advance. RSSLC indicated it was not yet in compliance with any of the provisions for Section U, as it was awaiting the final guidance in the form of the DADS statewide policy. The monitoring team concurred with this assessment. The POI and SPOI also assigned much of the responsibility for this section of the SA to the Rights Protection Officer, but the transition of most these responsibilities from the former position of Director of Social Services had not actually yet occurred.

	Summary of Monitor's Assessment: The monitoring team reviewed a sample of documents in order to be able to assess progress, if any, from the baseline tour and provide any additional recommendations that may be helpful to the Facility when it does undertake action in these provisions. The monitoring team found that the Facility was taking a measured approach to the issues of guardianship as it awaited the promulgation of statewide DADS Policy Number: 019 Rights and Protection, and this was to be commended. In addition, the Facility was to be commended for its approach to self-advocacy as a means to promote the capacity of individuals to make informed decisions. RSSLC had officially assigned, through its POI and SPOI, most of the responsibilities in this area to the Rights Protection Officer, but most of these duties were still being handled by the Transition Coordinator. It was not clear at what point the day-to-day responsibilities for planning and implementing these processes would be transitioned. This should be clarified as soon as practical. Additional findings are as follows: **Provision U1:** This provision was determined to be not in compliance. The Facility had made no significant changes to its tools or processes since the previous monitoring visit, in anticipation of the issuance of the statewide policy. The Facility expected to operationalize this policy once it was made available. In the interim, the assessment process for need for guardianship remained undefined and dependent on the processes of the particular PST. One area of progress was that PSTs were, in some instances, attempting to provide an individualized rationale for their decisions in this area. Given the tools and processes that should come with the new policy, the PSTs will be better equipped to accomplish this in the future. The monitoring team looks forward to reviewing how the PSTs use these new tools and processes at the next visit. The Facility also continued to maintain a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision. The placement of the individuals on the list was not made according to any standardized assessment, as described above, but did utilize certain specific criteria to determine a numerical priority. It was expected this prioritization process would be modified according to the requirements of the pending statewide policy. **Provision U2:** This provision was determined to be not in compliance. The Facility had not made any substantial changes in this area since the previous monitoring visit; rather, it had adopted an appropriately deliberate and careful stance toward the solicitation of guardians. It was awaiting further guidance in this area from DADs in the form of the new DADS Policy Number: 019 Rights and Protection. The Facility anticipated it would begin to operationalize this policy on a local level once received. It was also noted that PSTs were making a number of referrals to obtain advocates for individuals in lieu of seeking legal guardianship. This was a commendable approach to obtaining decision-making assistance for individuals while preserving their legal autonomy, but the Facility had not yet implemented a formal advocacy program and was seeking DADS guidance in this area as well. RSSLC should ensure that the qualifications, responsibilities and training required for advocates are spelled out in policy.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	This component was determined to be not in compliance. The monitoring team observed two PSPs and 14 Rights Assessments, and interviewed both the Rights Protection Officer and Transition Coordinator to assess the Facility's status in this area. No state level policy was yet available to implement this section of the Settlement Agreement, but a draft policy, DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship), had been promulgated and was under review at the time of the monitoring site visit. The Facility reported it had not made any updates to Facility policy and procedure as they await the final issuance of the state-level policy. A review of the draft DADS Policy Number: 019 indicated this document will provide direction to the PST as to its responsibility to address decision-making capacity using a more discriminating methodology, as well as its responsibility to develop, as appropriate, strategies to restore or otherwise enhance the capacity of individuals to make informed decisions. The Facility had not taken any action since the preceding monitoring visit to revise its processes or tools for assessing an individual's functional capacity to render a decision regarding the individual's health or welfare, or to its processes for referral for guardianship. For the two PSPs attended, both of the individuals had current guardians. There was no discussion during the PSPs as to their capacity to make decisions at any level, nor any discussion as to actions that might be taken by the team to restore capacity in any area. The monitoring team also reviewed the Rights Assessment documents for an additional 14 individuals. For 14 of 14 Rights Assessments, in the section related to informed consent, all six categories were checked to indicate the inability of the individual to give consent in that area. The PSTs had made some attempts to document the rationale for these decisions, but the documentation reflected that the Facility did not yet have a standardized tool or process to assess capacity. For 14 of 14 Rights Assessments, there were no references to a specific valid tool that was used to make the determination. For seven of the 14 Rights Assessments, the PSTs simply noted that the individual did not respond to questions or did not seem to understand questions as the justification. In several instances, the PSTs did reference the results of the Comprehensive Functional Assessment as a part of the rationale, but this instrument does not address capacity to give informed consent in a specific manner. It should be considered progress that PSTs were, at times, attempting to provide an individualized rationale. Given the tools and processes that should come with the new policy, the PSTs will be better equipped to accomplish this. The monitoring team looks forward to reviewing how the PSTs use these new tools and processes at the next visit.	N

#	Provision	Assessment of Status	Compliance
		There had been no action taken by the Facility to revise the prioritization criteria, as described in the baseline report, in maintaining its list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision. These processes and tools were expected to be prescribed in the draft policy, DADS Policy Number: 019 to be issued in the near future, so this was a reasonable approach. The monitoring team looks forward to reviewing these areas at the next site visit. In the interim, the Facility provided a prioritized list of 226 individuals. There were 107 individuals assigned a priority rating of zero on the priority list. All of these individuals had been adjudicated incompetent and most had current guardians. There were 45 individuals assigned a priority rating of one, some of whom had been adjudicated incompetent, but did not have a current guardian, while others did not indicate a guardianship status. There were seven individuals assigned a priority rating of two, and 58 individuals assigned a priority rating of three, according to the prioritization criteria in use. Nine individuals were listed with no priority assignment, indicating the list may need to be updated. The Facility reported it had not yet designed nor implemented a monitoring process for this provision, although it was noted that the PSP monitoring tool did ask whether there was a discussion of the individual's ability to give informed consent. Once the new DADS Policy Number: 019 Rights and Protection has been issued, the Facility should ensure its monitoring indicators and processes to be consistent with the policy's requirements, and it may find these data from the monitoring tool to be useful in that regard. Finally, RSSLC had continued to promote participation in self-advocacy as one means to enhance the capacities of individuals to make informed decisions, which the monitoring team found to be a valuable and commendable strategy. RSSLC Self-Advocates attended the statewide annual self-advocacy conference and there is a plan in place to assist them to become members of the Fort Bend County self-advocacy group in the community.	
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	This component was determined to be not in compliance. RSSLC reported it had not made any changes to its processes in the solicitation of guardians since the preceding monitoring visit, nor engaged in any activity providing guidance on the process of becoming an LAR, as it awaited the final issuance of DADS Policy Number: 019. The Rights Protection Officer and the Transition Coordinator both reported the Facility was not actively pursuing guardianships in most instances until the new DADS policy is issued, which the monitoring team found to be an appropriate strategy. Since that last monitoring visit, six individuals had received a guardian, but not pursuant to any newly implemented policy. Four of the six individuals had their guardianship moved from Harris County to Fort Bend County, while the remaining two	N

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	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.	received successor guardians after one guardian resigned and one passed away. It was reported that PSTs were making a number of referrals to obtain advocates for individuals in lieu of seeking legal guardianship. The Facility reported having a list of 50 individuals who had been referred to obtain an Advocate over the past year; however no advocates have been obtained. This was a commendable approach to obtaining decision-making assistance for individuals while preserving their legal autonomy, but the Facility had not yet implemented a formal advocacy program and was seeking DADS guidance in this area as well. RSSLC should ensure that the qualifications, responsibilities and training required for advocates are spelled out in policy, much as for LARs.	

Recommendations:

1. RSSLC had officially assigned, through its POI and SPOI, most of the responsibilities in the area of guardianship to the Rights Protection Officer, but most of these duties were still actually being handled by the Transition Coordinator. It was not clear at what point the day-to-day responsibilities for planning and implementing these processes would be transitioned. This should be clarified as soon as practical.
2. Facility PSTs should receive guidance and training from DADS to prescribe a process for how an assessment should be done to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance should be provided as to how, and how often, a need for guardianship should be periodically reviewed. The pending statewide policy is expected to provide approaches in these areas.
3. Once the statewide policy and assessment process has been finalized, RSSLC should develop facility-specific policies and procedures to operationalize the requirements.
4. The Facility should ensure its policy and procedure, once developed, include:
5. Clearly defined assessment and referral processes
6. Minimum criteria for individuals, organizations or entities the facility will solicit to act as an LAR for individuals, in order to assure individuals' rights and safety are protected.
7. The roles and responsibilities of the Facility in educating LARs and potential LARs in the roles and responsibilities of guardianship.
8. Once the new DADS Policy Number: 019 Rights and Protection has been issued, the Facility should ensure its monitoring indicators and processes to monitor PSPs and recommend need for an LAR are consistent with the policy's requirements. There should be a consistent process for follow-up on individual issues identified, as well as process for tracking and trending those issues that would benefit from quality improvement activity.
9. RSSLC should continue to make referrals to obtain advocates for individuals and should ensure that the qualifications, responsibilities and training required for advocates are spelled out in policy.

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SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI) 5/17/10 2. RSSLC Supplemental Plan of Improvement (SPOI) 7/5/10 3. DADS Policy 020.1 Recordkeeping Practices 3/5/10 4. RSSLC Policy A.6 Recordkeeping 10/4/10 (DRAFT) 5. Curriculum materials for inservice training a. Richmond State Supported Living Center Active Record Order & Guidelines 8/26/10 b. Power Point presentation Unified Record c. Unified Record Reorganization Project Mandatory In-service written psot-test 6. Filing Schedule for Active Record Order 9/29/10 (DRAFT) 7. Active Record—Things to Remember 9/22/10 8. DADS Policy and Procedure Tracking Tool undated 9. Active Records for Individuals #412, #448, #455, and #500 10. Group books at Trinity A 11. Group book at Environmental Safe Workshop 12. Reviews of Active Records by all monitoring team members **People Interviewed:** 1. Wanda Hartensteiner, Director, Medical Records 2. Raj Narsinghani and Tracy Stafford, Unified Records Coordinators (URCs) 10/27/10 3. DCP at Trinity A 10/27/10 4. Lenin Mathews, QMRP at Trinity 10/27/10 5. Kasey Barnett, Vocational Coordinator at Environmental Clean Workshop 10/28/10 **Meeting Attended/Observations:** 1. PSP for Individual #500 2. Human Rights Committee Meeting 10/28/10
	Facility Self-Assessment: The Facility reported that no Action Steps had yet been completed. This included conversion of records to the new format; however, conversion had been completed for all Active Records, with group books being used as the Individual Notebooks required by policy. The Facility reported accurately that many State policies have been revised but not all that are required to implement the Settlement Agreement. The Facility reported that it is to develop local policies after receiving revised State policies, but that had not been done in all cases. Action Steps related to utilize of records in making care, medical treatment and training decisions focused entirely on monitoring of records and developing corrective action plans. This will be inadequate. The use

	of records needs to be integrated into the processes of assessment, PSP development, and review of individual progress and status. These activities go far beyond the plans developed for improvement of Section V; actions to improve use of records must be integrated into other improvement planning and integrated with the procedures in the new PSP process. At a minimum, monitoring of PSPs and other meetings to determine whether discussions are integrated and information from records is part of those discussions (including data) will be required.
	Summary of Monitor's Assessment: RSSLC made progress toward compliance with the requirements of this Section. The new DADS recordkeeping policy and record format had been implemented for all individual records. Training had been provided. An audit process had been put in place that included identification of deficiencies, but it was informal, did not include written feedback or requirements for corrective action, and had no processes to determine whether corrective actions had been completed or to track and trend the findings of the audits. **Provision V1:** The Facility had established a new Active Record format following the Active Record Order and Guidelines and had completed conversion of all the unified records to the new format. Although most records were in generally good order, review of records found errors in filing, some missing assessments, some illegible entries (particularly signatures), and gaps that were not crossed through. **Provision V2:** Policy development and revision to support all provisions of Part II of the SA continued at both the statewide and Facility levels. **Provision V3:** Quality assurance audits had begun. Audits used the review checklist tool developed by the monitoring teams. URCs described deficiencies in writing in the comments section of the tool. The monitoring and corrective action process remained informal. There were no selection rules for determining which active records to review or how to identify records randomly. When something was found to be deficient and in need of corrective action, the URC spoke to the appropriate staff and requested a plan of correction. There was no process for corrective actions to be provided in writing to the Facility so that completion could be tracked. No process was in place to track areas needing correction or to identify trends that might lead to systemic changes in procedures or in retraining. **Provision V4:** Use of records for decision-making was variable. There was little review in PSP meetings of the prior year's progress or regression and little focus on using data from the records to make decisions.

#	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	The Facility had established a new Active Record format following the Active Record Order and Guidelines and had completed conversion of all the unified records to the new format. Per report from the URCs, conversion was completed in September, 2010, and all records reviewed followed this format, with group books being used as the Individual	N

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	and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Notebooks required by policy.. Conversion was done by the URCs along with the records clerks for one home at a time. Following conversion, the URCs report they returned to each home to check to see if there were problems and to go over changes that had occurred since the beginning of the conversion. Per report of the Director of Medical Records, campus-wide inservice was done over several days in July, 2010, including all shifts. Participants were required to take true/false tests; trainers then went over answers. Because there was no demonstration that the participants were able to implement the new records, this could not be considered competency-based instruction. Therefore, it will be important to track the results of audits of Active Records to determine whether additional training is needed. The Three Rivers and Four Rivers units asked the URCs to provide retraining to small groups of employees. The URCs reported that training was not included in new employee orientation. The Active Record required two, three, or four volumes, depending on the amount of information included; an individual section in the "group book" (which was used to meet the requirement of an individual notebook); and an overflow record in the Medical Records department. Nurses had a separate notebook that had the Monthly Flowsheet and the current month of the MARS, according to the Director of Medical Records. Group notebooks were available in each of the areas checked. Within a group notebook was a section for each individual that included the PSP, PBSP, PNMP, and program objectives with data sheets for the current month. Staff reported the PSP was accessible to them in their work areas. To determine whether Active Records were completed in compliance with Facility expectations and Appendix D of the SA, the monitoring team reviewed the complete Active Record (except for the Individual Notebook) for Individuals #412, #448, and #500. Although records were generally in order and, for the most part, complete and legible, none of the records met all the requirements. • For three of three records, there were items not complete, misfiled, or illegible. In each, some required assessments were not in the record. For Individual #500, the only assessments in the Assessment tab were the PALS summary and the water safety assessment. For Individual #448, there was no consent for restraint in the Active Record, but data show regular use of restraint. The PSP addendum was misfiled in PSP Reviews tab behind monthly review rather than	

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		in PSP tab and the PBSP was filed in front of peer and HRC reviews as designated in the Active Record Order. • For two of three records (Individuals #448 and #500), there were numerous gaps in the Observation notes sections. These ranged from two or three lines at the end of a page to an entire blank page. • For Individual #448, not all entries were in chronological order. Partial reviews of other Active Records identified similar errors: • For Individual #455, an Integrated Progress Note had a blank line at the bottom of one page. There was also a correction with cross-through and statement "Wrong Entry" written in (which would be appropriate), but there was no date or initials for the correction. • Individuals' identification information was not consistently on individual record sheets/form. • When imprint cards were used the identification information was difficult to read due to the poor ink quality and/or worn out card. • Entries were not consistently legible, particularly signatures Review of the Integrated Progress Notes indicated several recordkeeping issues of concern: • When the new record organization was implemented order of the entries in the Integrated Progress Notes changed. Although pages in the Integrated Progress Notes are in order from most recent to oldest, each page has oldest entry on the front and newer entries on the back. This resulted in many blank pages because often the writers began their entries on the next top page as opposed to writing on the back of the first page. This caused the entries to be out of sequence and made following clinical information confusing and difficult to read. Entries made by various disciplines were written on a separate Integrated Progress Note or sheet of paper and inserted into the Integrated Progress Notes in somewhat of a chronological order, particularly physicians' notes, as opposed to writing on the Integrated Progress Notes. Again, this made the sequence of the clinical information difficult to follow. The Facility should evaluate the sequence and process in which Integrated Progress Notes are written to ensure that the notes follow a logical sequence. • Nurses' entries for time and/or dates were not consistently documented in chronological order in the Integrated Progress Notes. The Integrated Progress Notes relating to individual #740 were out of chronological order making it difficult to follow the clinical course of treatment. • Often single entry documentation was written on an Integrated Progress Note with a line drawn through the remainder of the blank page, when the entry	

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		should have been written chronologically on the existing note. Development of an electronic health record was in process. The Facility had a share drive folder called the Virtual Client Folder (VCF) in which were found assessments, consultations done at the Facility, and some databases. All clinicians had access to all the information on the VCF, which could provide a way to share information as part of PST planning. Expansion of this system could serve as a step toward an electronic health record by adding information that can be used routinely for decision-making and to help clinicians become used to viewing information from other disciplines.	
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.	Both DADS and RSSLC had continued to revise and develop policies needed to implement the requirements of the SA. DADS provided a tracking sheet with status of policy revisions. As DADS policies have been revised, Facility policies have not always been revised as needed to ensure compliance with DADS policy. Not all policies were yet revised to support all provisions of the SA, but progress had been made. For example, DADS Policy 020.1 Recordkeeping Practices was implemented 3/05/10. The RSSLC Recordkeeping Policy was in process of updating; a checkout system will be addressed in an updated policy. In July, 2010, DADS implemented a new policy on the PSP process. The DADS policy is being implemented without the benefit of updates to RSSLC policies. As noted in the "documents reviewed" section of the Steps Taken to Assess Compliance, RSSLC had many policies directed at the PSP process. RSSLC reported it was in the process of revising facility policies to address the new PSP process. DADS reissued its abuse and neglect policies on 6/18/10. Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation and Policy 02.2 Incident management supersede Policy 02.1 which covered both topics. Policy 2.2 includes as an exhibit the Memorandum Of Understanding between DADS, OIG, and DFPS. These policies include changes resulting from recommendations from the monitoring team's baseline reviews and clearly reflect an absolute prohibition of abuse and neglect and require timely reporting. RSSLC had a comprehensive set of policies defining and governing use of restraints. These policies did not always define restraint consistent with the definitions in the SA and in DADS policy. They also did not always include some of the specific requirements of the DADS policy. The Chief Nurse Executive participated with the Statewide Nursing Workgroup to develop Nursing Policies and Procedures to be used by all State Supported Living Center	N

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		nursing staff. The Nursing Department had adopted and a number of state policies, which are listed in Provision M4.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	The quality assurance and random review process had just begun. The structured audit process began in October, 2010, although informal audits were conducted during September, 2010, as the URCs returned to each home to determine whether there were any problems. Eight audits had been completed in October, 2010. Audits used the review checklist tool developed by the monitoring teams. URCs described deficiencies in writing in the comments section of the tool. The URCs had not reviewed the same record independently to determine whether they agreed on findings. The monitoring and corrective action process remained informal. There were no selection rules for determining which active records to review or how to identify records randomly. When something was found to be deficient and in need of corrective action, the URC spoke to the appropriate staff and requested a plan of correction. There was no process for corrective actions to be provided in writing to the Facility so that completion could be tracked. No process was in place to track areas needing correction or to identify trends that might lead to systemic changes in procedures or in retraining. The URCs reported that DADS is developing a database. They reported that the Facility had drafted a database and shared that with DADS, but no action was planned until DADS completed the database so it would be consistent across SSLCs. There were a few examples noted by the monitoring team of inappropriate language used in Integrated Progress Notes. For example, a 7/10/10 note for Individual #476 described enteral feeding as "New bag of feed set up…" As audits are completed, they should identify when inappropriate language is used, although that is not specifically listed on the audit checklist as an item to review.	N
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	There was concern about the accessibility of records to the staff who needed to use them. As an example, records were not immediately found to be brought to the monitoring team on several instances. The Facility is developing a check-out/accountability process. Group notebooks were available in each of the areas checked. Within a group notebook was a section for each individual that included the PSP, PBSP, PNMP, and program objectives with data sheets for the current month. However, it was often difficult for clinicians and QMRPs to use the new format for the records, as indicated by these examples:	N

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		• It could be difficult for QMRPs to review all information through the use of the Active Record. Assessments are spread throughout—in each discipline rather than in one place where all assessments can be viewed together. Because books break at different points based on the amount of information in a binder, it was cumbersome to figure out what is in each book, which caused the QMRPs and clinicians to take added time when they pull out the wrong binder. • Assessments that were occurring outside of the annuals (for example, when there was a change of status) were listed within the IPNs or Habilitation Services Notes. The location of where the observations were listed was inconsistent and at times was listed in one or the other and at other times listed in both. Examples of this issue may be found in the records of Individuals #217 and #634. Nursing and DCPs used multiple forms to track basic areas of health care (i.e., vitals, bowel, temperature, intake, emesis, and weight). The use of multiple forms results in increased difficulty to draw conclusions and to clearly identify connections between these areas. This results in a possible delay in acquiring the needed data to expedite care. Use of data from the records was variable. There was little review in PSP meetings of the prior year's progress or regression and little focus on using data from the records to make decisions. For 4 of 4 PSPs observed during the monitoring visit, the PST failed to ensure assessments and their results, particularly as they related to potential risk factors, were sufficiently addressed in the development of the annual plan.	

Recommendations:

1. RSSLC should ensure it is easy to find information in the records, even if that requires purchase of new and larger binders and developing a process to identify at a glance which binder has which information.
2. Develop and implement a formalized records audit system that provides written results of audits; includes a process to require corrective action, tracks whether the action has been completed, and checks a sample of actions to ensure reports of completion are accurate; tracks and trends findings of the audits' and includes trending of findings of the audits in the Facility QA process so it can lead to systemic process improvement plans.
3. Include training on recordkeeping in New Employee Orientation.

List of Acronyms Used in This Report
Richmond SSLC
October 25-29, 2010, Compliance Visit

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ACP	Acute Care Plan
AED	Anti-Epileptic Drug/Automated External Defibrillator
ADL	Activity of Daily Living
ADR	Adverse Drug Reaction
AIMS	Abnormal Involuntary Movement Scale
ANA	American Nurses Association
A/N/E	Abuse/Neglect/Exploitation
AP	Alleged Perpetrator
APC	Admissions/Placement Coordinator
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
BCBA	Board Certified Behavior Analyst
BP	Blood Pressure
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
CBC	Criminal Background Check
CDC	Centers for Disease Control and Prevention
C-Diff	Clostridium Difficile
CLDP	Community Living Discharge Plan
CLO	Community Living Options
CLODR	Community Living Options Discussion Record
CLOIP	Community Living Options Information Process
CMS	Centers for Medicare and Medicaid Services
CEU	Continuing Education Unit
CNE	Chief Nurse Executive
COP	ICF/MR Condition of Participation
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CSO	Campus Supervision Overnight
CTD	Competency Training and Development
CV	Curriculum vitae (resume)
DADS	Texas Department of Aging and Disability Services
DCP	Direct Care Professional
DD	Developmentally Delayed
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale

DOJ	U.S. Department of Justice
DMID	Diagnostic Manual-Intellectual Disability
DRO	Differential Reinforcement of Other Behavior
DSM/DSM IV TR	Diagnostic and Statistical Manual of the American Psychiatric Association
DUE	Drug Utilization Evaluation
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FSPI	Facility Support Performance Indicator
FTE	Full Time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal reflux disease
HCG	Health Care Guidelines
HCP	Health Care Plan
HIPAA	Health Information Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMP	Health Maintenance Plan
HOB	Head of Bed
HRC	Human rights committee
HO	Human Rights Officer
HST	Health Support Team
IBW	Ideal Body Weight
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IDT	Interdisciplinary Team
IMC	Incident Management Committee
IMRT	Incident Management Review Team
ISP	Individual Support Plan
i.v.	Intravenous
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
MD/M.D.	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphyloccus Aureus
NA	Not Applicable
NCP	Nursing Care Plan
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NP	Nurse Practitioner
OIG	Office of the Inspector General

OJT	On the Job Training
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
O2Sat	Oxygen saturation
PALS	Positive Adaptive Living Survey
PAO	Physical Aggression toward Others
P&P	Policies and Procedures
P&TC	Pharmacy and Therapeutics Committee
PBSP	Positive Behavior Support Plan
PBST	Personal Behavior Support Team
PCD	Planned Completion Date
PCP	Primary Care Physician
PDB	Physically Disruptive Behavior
PDP	Personal Development Plan
PFA	Personal Focus Assessment
PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PMR	Psychiatric Medication Review
PMT	Psychotropic Medication
PRN	Pro Re Nata (as needed)
PNM	Physical and Nutritional Management
PNMC	Physical and Nutritional Management Coordinator
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
POC	Plan of Correction
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy
PTR	Psychiatric Treatment Review
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RN	Registered Nurse
r/o	Rule out
RSSLC	Richmond State Supported Living Center

SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/Analysis, and Plan charting method
SSLC	State Supported Living Center
SPCI	Safety Plan Crisis Intervention
SPO	Specific Program Objective
SPOI	Supplementary Plan of Improvement
SQRA	Standard of Quality for Risk Assessment
STAT	Immediate
STD	Sexually Transmitted Disease
TB	Tuberculosis
UIR	Unusual Incident Review or Unusual Incident Report
VCF	Virtual Client Folder
VDB	Verbally Disruptive Behavior
VNS	Vagal Nerve Stimulator
VRE	Vancomycin-resistant enterococcus