United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center
May 1-6, 2011

Date of Report: July 21, 2011

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Introduction

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 Monitoris 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 are 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.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. However, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. Several sections of this report include information provided by multiple team members.

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 tomake 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 facilitiesare free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the SA.

Methodology

In order to assess the facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week of the tour, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

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

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

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement.

The report 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, the report includes the following sub-sections:

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;

b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report. It should be noted that the Action Steps listed by RSSLC are a plan of improvement and may not be fully in congruence with, or may not at a given time address all, components of the SA that are being reviewed. The Assessment of Status by the Monitoring Team, 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;
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 (it should be noted that these are only selected examples from reviewed documents and observations, and the Facility should not address these as if they are the only examples that could have been provided of these practices and outcomes);
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.The recommendations for some provisions include a subsection of additional suggestions for the Facility. These are presented in an effort to assist the Facility in prioritizing activities as the Facility staff work toward achieving substantial compliance with the provision.

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request form the parties to protect the confidentiality of each individual.

Executive Summary

First, the Monitoring Team wishes to acknowledge and thank the individuals, staff, clinicians, managers, and administrators of the Facility for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. As usual, the Facility and State approached the Monitoring Team's review with openness and cooperation. The Facility made available to the Monitoring Team anumber of staff members in order to facilitate the many activities required, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations.The Monitoring Team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Judy Miller, and her staff, who worked tirelessly before, during, and after the visit to ensure members of the Monitoring Team received the information they needed to conduct the review.

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 the Facility. 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 and clinicians. 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.

As a result, a great deal of information was obtained, as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations conducted, and interviews held. Specific information regarding many individuals is included in this report, providing a broad sampling from all homes and across a variety of individual needs and supports. It is the hope of the Monitoring Team that the information and recommendations contained in this report are credible and helpful to the facility.

As noted in various sections of this report, the Monitoring Team identified some areas in which the Facility had made progress. There were also a number of areas, including some that had a direct impact on the health and safety of individuals, in which concerted efforts need to be made to improve the supports, service, and protections provided to individuals. Many of the improvements as well as the areas in which improvement is needed are briefly summarized below.

At RSSLC, it was noteworthy that the departments and disciplines that were achieving success were doing so in part because the immediate administrators of those areas were taking a great deal of initiative. These administrators were achieving improvement, according to observations and interviews, because of personal motivation and a dedication to the Settlement Agreement process.

At the time of the compliance visit, the Facility served a population of 384 individuals.

Improvements and Positive Practices: Following is a brief summary of some of the improvements and positive practices noted during this visit.

Restraints

- The Facility had initiated a process to audit restraint records. Although too recent to effectively minimize documentation errors, the process is a positive step in doing so.

Abuse, Neglect and Incident Management

- Investigations were completed using a standard format, and, for the most part, were conducted in a timely fashion. Some documentation issues still needed to be addressed, such as recording supervisory reviews and their content.
- Training for staff on abuse and incident reporting was in place, and all staff were current in that training.
- The Facility had hired additional investigators so that an investigator is onsite 24 hours a day seven days a week.
- The Facility had also implemented a video surveillance program since the last review.
- The Facility established an Administrative Review Team to review all Client Injury Reports (CIRs) and Incident Information Reports (E.17s). This group meets twice a week. This process is an additional process to the ordinary work processes that include document review and should result in improved performance. The Facility is commended for its initiative in this area.
- In every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no contact status.
- The Monitoring Team would like to commend the RSSLC for convening periodic joint meetings with DFPS and OIG at which any issues of mutual cooperation can be reviewed and resolved.

Quality Assurance

- QA systems are in place and are in various stages of development, refinement, and maturation, including the development of a data system that can consolidate data from monitoring and program auditing and produce compliance reports. This process has begun to produce Compliance Reports in some areas.
- RSSLC produces a monthly Allegations Trend Report, a monthly Unusual Incidents Trend Report, a monthly Injury Trends Report, and a monthly Restraint Trend Analysis. These reports contain most of the required elements required by the SA for the current report month.
- The QA director presented the Monitoring Team with a set of monitoring tools that corresponded to many of the provisions of the Settlement Agreement. Each tool consisted of a set of checklist-type items and had an attached set of instructions for completing each item of the tool. These tools were designed to be used at all of the SSLCs, were generated by DADS central office, and were based upon a set of tools originally used by the Monitoring Teams and developed in

2009. Some tools were slightly modified by RSSLC and the facility had created a compliance database to record monitoring findings and assess progress over time. The database presented to the Monitoring Team, which was developed in collaboration with the El Paso SSLC, appeared to have all the features necessary to eventually produce meaningful reports from well-organized data.

Integrated Protections, Services, Treatments and Supports

- The Facility had implemented a quality assurance process that is intended to identify and remediate the most apparent problems observed during a PSP meeting. The Monitoring Team commends the Facility staff for this quality assurance activity.
- DADS had issued new policy direction on PSP development in July, 2010 and many RSSLC policies had been revised, some very recently, in light of the new State policy on PSP planning. The training curriculum accompanying this new policy entitled "Supporting Visions" was intended to reinforce the concept that planning is intended to support the individual's vision for the future for him/herself. RSSLC received training on the new policy beginning in August, 2010.

Integrated Clinical Services

- Actions taken by the Facility demonstrate a commitment to moving toward integrated planning. These included training staff in the new PSP process, initiation of a weekly Integrated Morning Meeting to discuss specific cases, and establishment of a weekly psychiatric clinic with interdisciplinary involvement. The Integrated Morning Meeting involves numerous staff representing a variety of disciplines including direct care; this meeting discusses selected individuals who present complex issues or changes in status.

Minimum Common Elements of Clinical Care

- The Facility had taken actions that should improve the review of clinical indicators and the use of indicators to trigger assessments and revisions in treatments and interventions. Although these have not yet led to compliance with provisions of this section, and additional actions will be needed, they should continue. These actions include:
  - The weekly Integrated Morning Meeting
  - The development and expansion of the Acute Clinical Indicator process, which is intended to provide Clinical staff with greater insight in the management of acute medical conditions at the Facility. The Medical Director continues to develop the process.
  - The Skin Integrity Committee
  - A medication variance committee that involved several relevant disciplines.

At-Risk Individuals

- The new statewide risk assessment procedure, with improved guidelines for rating risk, had been initiated.

Psychiatric Care and Services

- All psychiatrists were board certified, and all had sufficient experience with intellectual disabilities. The staff psychiatrist actively and appropriately participated in the interdisciplinary process.
- Reiss Screens were administered to all individuals who required them, and a process was underway to complete psychiatric evaluations for all individuals who required them.
- Monthly reviews were conducted in the psychiatric clinics for all individuals who were treated with psychiatric polypharmacy. The Facility had established a committee to provide facility-level reviews of polypharmacy practices, and to assure that medication reduction plans were in place for individuals who needed them.
- Individuals received required screen for medication side effects, and the Facility had established a process for facility-wide monitoring of the results of the screening.

Psychological services

- A system for assessing staff competence and providing competence-based training for DCP staff had just been implemented by the Behavior Services department.
- Evaluation of Positive Behavior Support Plans (PBSPs) indicated they were written at a reading level that made them likely to be readable.
- The Director of Behavioral Services had extensive experience in the field of intellectual and developmental disabilities, and was board certified in applied behavior analysis.

Medical Care

- The Medical Staff had put forth significant effort in their development or enhancements of medical related policies, procedures, and practice.
- The Facility had developed and partially implemented a "Chronic Clinical Indicators" process that is intended to provide Facility Clinicians with up to date knowledge of current clinical standards of care for common and serious conditions.
- As part of an Aspiration Pneumonia Prevention Plan, the Facility developed an "Aspiration Clinical Pathway." The pathway was developed by medical and other professional staff at the Facility and was in-serviced to nurse managers, clinicians and members of the pneumonia committee.
- The Medical Director initiated an "Integrated Morning Meeting." The meeting consists of all clinicians, psychiatrist, clinical pharmacist, habilitation coordinator, nurse case managers, QMRPs, behavior analyst, unit directors and direct care staff, and meets every Wednesday to discuss a predetermined case, which is based on changes in functional status of an individual, or if there was recent and challenging hospitalization of an individual.
- The Medical Director had established a process to improve communication and working relationships with local hospital systems.
- Since the last the review the Facility had made improvements in the Emergency Response System. A formalized Mock Medical Emergency Drill Schedule was implemented and the Facility tracked completed drills. An Emergency Response

Committee was established and implemented to analyze and trend Mock Medical Emergency Drill data, take corrective action when necessary, and to improve the Mock Medical Emergency Drill procedures. Review of the Committee minutes since the initial meeting showed progressive improvement in the analysis and trending of the completed Mock Medical Emergency Drills as well as corrective action taken when employees failed to perform adequately at the drills.

- The recently initiated statewide Medical Chart Audit is an excellent mechanism to help identify various activities by the clinicians, such as documentation practice and following up on various conditions.

Nursing Care

- The Nursing Department continued to maintain nursing staffing without the use of agency nurses. It was positive to find since the last compliance review that the Nursing Department had developed and implemented a new policy for documenting nursing staffing coverage on 4/1/11.
- Since the last compliance visit the Nursing Care Monitoring Tools had been reduced from 21 to 12. Interpretative Guideline had been developed to ensure that all monitors evaluated data in like manner and to address the quality of the clinical data. The Nursing Department in collaboration with the Quality Assurance Department trained the nurses on the use of the monitoring tools and began monitoring with the tools.
- In addition to the Quality Assurance Nurses auditing the 12 Nursing Care Monitoring Tools, they also monitored other items that included: Emergency Equipment, Medication Rooms, positioning of individual according to their Physical and Nutritional Plans, Medication Administration Records, Narcotic Logs, and Medication Administration Observations.
- It was positive to find that the Nursing Department had self initiated a process for improving documentation, including a comprehensive Documentation Audit process. It was impressive that this initiative had resulted in a 41% decrease in documentation errors for the documentation items audited. There was evidence that improvements were found in the technical quality of the documentation. The SOAP method of charting was used almost consistently.
- At the time of the compliance review the Facility did not have any active pressure sores. The Wound Care Nurse continued to maintain a Decubitus Tracking Report by the month. The tracking report included whether pressure sores were acquired at the facility or were hospital acquired.
- Significant improvement was found with the development and implementation of the Medication Error/Variance Policy and formation of a Medication Error/Variance Committee.

Pharmacy Services and Safe Medication Practices

- The Monitoring Team noted exceptionally high quality of QDRR reviews.
- The Facility implemented an effective process to monitor the use of STAT medications, especially employing an electronic database that enables efficient and effective review of STAT medications, and the Pharmacy and Therapeutics Committee(P&TC) effectively reviewed the data to make meaningful decisions.
- The Monitoring Team was impressed by the comprehensiveness of the medication error reports and the Facility's new process to address medication variances at the Facility. The new Medication Variance Committee was noted to offer

significant insight and meaningful recommendations for medication variances. Importantly, the Monitoring Team was especially pleased to note that all relevant disciplines are taking appropriate action in reporting variances at the Facility. The Monitoring Team was also impressed that staff are beginning to self-report medication variances at the Facility.

Physical and Nutritional Management

- A new monitoring form was developed that focuses on PNM risks throughout the individual's day. The new document covers the areas of meals, snacks, oral care, medication administration, and positioning.
- There were several practices related to the PNMP that the Facility should ensure continue,
    - Positioning instructions for wheelchair and alternate positions instructions were included as applicable.
    - Transfer instructions were included as applicable.
    - Mealtime/dining plan included intake information for mealtime and snacks.
    - Mealtime/dining plan included food/fluid textures as applicable

Physical and Occupational Therapy

- An initial OT/PT Comprehensive Evaluation was completed for each individual upon admission.

Dental Services

- The Dental Office was equipped with relatively modern technology and appeared to be in order and clean. Despite possible staffing and resource limitations, the Dental office was well managed. The Dental Director demonstrated a level of professionalism and commitment to individuals served by the Facility that was commendable.

Habilitation, Training, Education, and Skill Acquisition Programs

- Some improvement was noted in task analysis and skill acquisition training.

Most Integrated Setting

- Fifteen individuals had transitioned to a community placement in the past six months, which was a relatively high pace
- The Facility had begun completing Facility Pre-Move Site Reviews for individuals who were moving to the community. In one such instance, the Pre-Move Site Review found that certain in-services that had not been provided, although the MRA Continuity of Care Pre-Move Site Review had not identified this issue. The move date was delayed as a result until the in-services were completed.
- The Facility had undertaken much activity in providing staff in-service regarding most integrated setting, community living and transition, which was a positive step. The Monitoring Team commends the Transition Coordinator and the Facility for this initiative and would recommend that all of this activity be consolidated into an overall strategic plan for community education and awareness that also places an emphasis on promoting awareness and decision-making capacities for individuals.

- PMM Checklists reviewed were being completed in a timely manner.

Consent

- The Facility continued to offer significant opportunities for self-advocacy, which the Monitoring Team found very commendable.

Recordkeeping and General Plan Implementation

- The Facility maintained a Unified Record for each individual. The Unified Record at RSSLC consisted of an Active Record, Master Record, and an individual section in a Group Notebook. Active Records were filed in two, three, or (in a few cases) four charts, depending on the amount of documents involved.
- A Record Order & Guidelines listed the order of documents and the maintenance guidelines that stated how long each document should remain in the Active Record; this was filed in the front of every chart.
- Policy for recordkeeping at the Facility was specified in policy A.6 Recordkeeping. This policy was consistent with DADS recordkeeping policy and with Appendix D of the SA. In addition, the facility policy contained additional information and notes to operationalize the policy.
- Review of records for a sample of individuals showed that they approached compliance with Facility expectations and Appendix D of the SA. Although records were generally in order and, for the most part, complete and legible, none of the records met all the requirements. Nevertheless, the records showed improvement over time since the baseline visit. Records could be found and provided quickly, and staff could show where documents for individuals were in the group notebooks.
- The Facility had initiated training new staff during new employee orientation and new nurses during their new nurse orientation. The training for new employees provided a good description of the rules for recordkeeping found in Appendix D.
- RSSLC had initiated a robust record audit process that includes audits by Unit Clerks, with the Unified Records Coordinators reviewing a sample of those done by the Unit Clerks to determine inter-rater reliability. These audits include the Active Record and the Master Record. A second audit process also existed in which Program Monitors reviewed the share drive to determine whether assessment reports had been posted and also, following the annual PSP planning meeting, checked the group notebook for the presence of SPO and SSO data sheets. These two complementary processes provided considerable information that was entered into a database that provided reports on compliance with requirements.

Areas in Need of Improvement: Following is a summary of improvements that continue to be needed.

Restraints

- Since the last review the RSSLC revised its primary restraint policy J.1 to mirror the State policy on restraint. Some of the supplemental restraint policies need revision, as they do not always reflect definitions and terms that are consistent with the primary policy.
- Crisis intervention restraint use at RSSLC has remained relatively constant over the last 15 months. Practices in behavioral services need to be effectively addressed in order to reduce the use of restraint at the RSSLC, especially the use of chemical restraint.
- Data on restraint use are not trended over time, which restricts their usefulness in identifying anything appearing to need special attention or focused intervention by clinical staff.
- There were many instances of incomplete or incorrect documentation of restraint use. None of the restraint records included use of the required Face-to-face Assessment/Debriefing document required by State policy and many did not include an alternative document used by the RSSLC. Additional staff training is needed.
- Medical staff has not been consistently establishing restraint monitoring protocols for chemical crisis intervention restraint and medical restraint specific to each episode of restraint. Nursing staff have not been consistently monitoring individuals in chemical crisis restraint or medical restraint correctly largely due to the absence of doctor ordered specific monitoring protocol. Additionally, nursing staff have not consistently been monitoring individuals in restraint post-release in accordance with policy.
- The process for review of individual restraint episodes needs substantial improvement including a more clinical orientation.
- Restraint documentation reported in many cases that the individual's Positive Behavior Support Plan (PBSP) and Safety Plan (SP) were not implemented in an attempt to avoid the need for restraint.

Abuse, Neglect and Incident Management

- RSSLC policies relevant to incident management are difficult to follow; several could be combined for ease of understanding and administration. These policies did not fit together in a logical presentation of either Facility policies or procedural practices. This has two consequences. First, many things required to achieve compliance with the SA were not in policy or were not stated clearly; second, staff trying to comply with policy may often become confused as they attempt to understand how certain policies apply to their daily work.
- Work continued to need to be done to ensure that staff were competent in understanding signs and symptoms of abuse, their responsibilities with regard to reporting, and the reporting procedures.
- Improvement was needed in the inclusion of adequate recommendations based on the results of investigations, and follow-through on those recommendations. Facility investigators made recommendations, but they more often related to the immediate protection of the individual as opposed to systemic issues they encountered.

Quality Assurance

- Only a limited data set for QA data is displayed for a rolling 12-month period, limiting its utility in trend analysis. The other trend reports generated by the RSSLC similarly do not present rolling 12-month data, which limits their usefulness in fully analyzing trends and targeting administrative and programmatic actions which may be needed to address particular issues, especially systemic issues, in particular locations, at particular times, or with particular staff and individuals.
- While the Facility had begun to demonstrate a capacity to generate corrective action plans responding to sentinel events, it had not as yet developed the capacity to develop and implement corrective action plans that address problems identified through the quality assurance process.To meet this requirement of the SA the Facility must be able to demonstrate its QA process is collecting sufficient data from which comprehensive analysis can produce the identification of underlying systemic causes of problems that can be addressed through facility-wide, or department-wide, improvement initiatives.

Integrated Protections, Services, Treatments and Supports

- The new PSP format and process was being implemented at RSSLC but with limited success specific to the requirements of this section of the SA. PSTs often failed to conduct comprehensive assessmentsof sufficient quality to reliably identify the individual's strengths, preferences and needs. The Monitoring Team found this to be a pervasive issue at the Facility that will need immediate and sustained attention to remediate.
- The PFA process was not being implemented in a manner that was either timely or meaningful to the individuals for whom the plan was being developed.
- PSPs did not consistently specify 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 and meet identified needs, nor did barriers to living in the most integrated setting always lead to goals, objectives, or service strategies.
- The lack of revision to inadequate data collection and presentation practices will continue to be a substantial impediment for RSSLC in making progress toward compliance with this portion of the Settlement Agreement.

Integrated Clinical Services

- An overall facility plan was not in place to address integrated clinical services, although a number of activities were occurring (see below). A facility policy did not exist; however, a draft DADS statewide policy was available. This state policy was not yet complete.
- The new PSP process is intended to promote integrated planning, Although progress had been made in development of interdisciplinary participation in a number of areas and the PSP planning meeting no longer involved reading of reports and recommendations, the process remained multidisciplinary in the sense that much decision-making still was done by disciplines rather than through thorough PST discussion.

- There was still a lack of participation by some disciplines, including direct care professionals, physicians, and speech therapists. Attendance by psychiatrists is limited due to staffing issues, but the lead psychiatrist attempted to attend as many PSP meetings as possible.

Minimum Common Elements of Clinical Care

- Provision of assessments on both a regular basis and in response to developments or changes in an individual's status was not consistent across all disciplines. Regular assessments were not consistently done as scheduled. Assessments also did not always occur in response to change in an individual's health status.
- Although most diagnoses were consistent with the conditions listed in the DSM and ICD codes, some were not.
- Interventions were not always revised when progress was not occurring or when changes in status occurred.
- Availability, use, and documentation of clinical indicators continued to need improvement.

At-Risk Individuals

- RSSLC does not identify risk timely and appropriately, which in turn prevents the development of timely and appropriate risk mitigation plans.
- Most risk assessments were not conducted within five working days of risk identification or a change in circumstances.
- Professional staff implementation of the Risk Assessment policy was inconsistent indicating a need for additional training and professional oversight.
- Interdisciplinary discussion required to properly assess risk and develop risk mitigation strategies was not apparent.

Psychiatric Care and Services

- In many cases, different diagnoses were cited in the various sections of an individual's clinical record.
- Many individuals had unresolved "not otherwise specified" (NOS) or "rule out" (r/o) diagnoses
- A number of cited diagnoses were not linked to specific behavioral characteristics of proposed disorders.
- There was some improvement in the area of the appropriate use of psychotropic medications. However, clinical records often did not indicate the reasons that various psychotropic medications were prescribed, and medication treatments were not linked to specific behavioral characteristics of proposed disorders.
- The Facility had a credible program to reduce the need for pretreatment sedation. However, that program had not yet been applied to all individuals who received pretreatment sedation for routine medical and dental procedures, and efforts to develop quality assurance procedures for the program were still under development.
- A full time psychiatrist had resigned, and the facility did not have a sufficient number of psychiatrists to provide the services required by the SA.
- The Facility had successfully deployed the use of Appendix B evaluations for about 140 individuals. However, the evaluations for many individuals did not fully follow the required format.

- Although behavioral data were considered in decisions regarding pharmacological treatments, a process was not in place to provide integrated behavioral care through combined assessment and case formulation.
- Adequate procedures were not in place for the PST (including the psychiatrist, primary care physician [PCP] and nurse) to evaluate risk benefit evaluations of proposed medication treatments, and to consider alternative treatments.
- The Facility did not have a process to track new prescriptions of psychotropic medications or changes in dosage and could therefore not ensure tracking of side effects was done as needed other than at regularly scheduled assessments.
- The Facility did not have a system for psychotropic medication treatment plans.
- Since there were no medication treatment plans, legally authorized representatives (LARs) could not be properly informed about proposed medication treatments.

Psychological services

- RSSLC had not addressed weaknesses in the data collection and graphing procedures that had first been noted during the baseline visit. The "DRA Data Sheet" remained the sole tool for collecting data even though this tool is not appropriate for many topographies and frequencies of treatment targets. Data graphs continued to present data only as mean daily displays even though this format was not appropriate for many types of target parameters such as severity and behaviors that are presented in bursts.
- The assessment of behavior, intellectual ability, adaptive ability, and mental illness also continued to reflect the same weaknesses noted during the baseline site visit. No progress had been achieved in regard to timely assessment of intellectual and adaptive skills. Although there was expanded use of anecdotal assessments of behavior functions and preference assessments, there was a continued lack of sophistication and expertise noted in the assessment of behavior.
- Many PBSPs continued to include intervention strategies that were not supported by the available assessments. Instructions to staff lacked specificity and substantially reduced the probability of consistent implementation.
- Baseline or comparison data were typically several years old or unrelated to current circumstances, preventing the determination of efficacy for PBSPs.
- In several cases, timeframes for consent and approval of behavior treatment plans had not been met.
- There were several individuals for whom PBSPs to address potentially harmful behavior were unsuccessful and yet had not been reviewed or revised in several months.
- Instructions to staff in PBSPs lacked specificity and substantially reduced the probability of consistent implementation.

Medical Care

- Significant and prompt work is needed to enhance nursing staff's ability to triage acute and decompensating chronic medical conditions, and direct care staff's appropriate and timely reporting of changes in status, and that improved reporting of clinical status updates to clinicians is fundamental to compliance.
- Documentation practices must be enhanced to better delineate clinical issues, diagnostics, treatments, clinical plan, and outcomes of clinical conditions.

- Nurses did not consistently participate in emergency drills and physicians never participated in the drills.
- The requirements for completing the various death review processes and timelines were not consistently met. The disciplines required to attend the Death Review Committees were not consistently present. Recommendations were not carried out timely. The Facility did not have a database to track recommendations to resolution. The Facility had two policies that were inconsistent in the required processes and timelines.

Nursing Care

- Although there was documented evidence contained in the completed Nursing Care Monitoring Tools that demonstrated that the Quality Assurance Nurses were beginning to analyze the available data and take immediate corrective action with individual nurses when deficiencies were identified on the monitoring tools; there had not yet been corrective actions on systemic issues.
- The decubitus tracking report failed to analyze and trend pressure sore data. The Wound Care Nurse needs to develop and implement a trend analysis to identify systemic skin integrity problems so that corrective action plans can be established and implemented to prevent or minimize skin integrity issues.
- The Infection Control Nurses continued to track and report infectious disease data into the database developed at the last compliance review. However, the database had not yet been fully populated with all of the data that the database is capable of handling.
- Although the Nursing Department had provided additional training on completing Quarterly and Annual Comprehensive Nursing Assessments, and it was apparent the nursing staff were making concerted efforts to appropriately complete comprehensive nursing assessments, there was improvement in all sections of the assessment except with the overall nursing summaries. The Nursing Department needs to enhance competency-based training on how to analyze and summarize clinical data into a meaningful summary that reflects the progress or lack of progress toward achieving individuals' established goals and objectives for each identified health problem.
- Although the Nursing Department had provided additional training on developing Health Maintenance Plans and Acute Care Plans since the last compliance visit, little progress had been made toward individualizing plans to meet individuals' unique heath care needs.
- Although improvements were made with increased monitoring of medication administration practices and documentation since the last compliance review, the nurses in the Infirmary need to improve medication administrations practices.
- The Nursing Department needs aggregate Medication Administration Observation data into a system to track, analyze, and trend the data to identify systemic issues and take corrective action on identified deficiencies.

Pharmacy Services and Safe Medication Practices

- The Facility did not have a process to track new prescriptions of psychotropic medications or changes in dosage and could therefore not ensure tracking of side effects was done as needed other than at regularly scheduled assessments.

- Although it was evident that the Facility had made efforts in improving its ADR process, there is a lack of appropriate monitoring and documentation following an ADR.
- The Monitoring Team acknowledged the high quality of the DUEs that were offered during the past six months; however, before compliance can be accomplished, the Facility must develop a policy that reflects its process, ensures that meaningful and appropriate recommendations are clearly delineated, and requires that a formal process is in place to provide additional DUEs when clinically necessary, such as when the FDA or manufacturer of a drug initiates a new warning. Also, a robust system must be developed to ensure that outcomes from the DUE are assessed and that competency training is afforded to relevant staff.
- Given the number of medications procured for the Facility, number of prescriptions written, drugs dispensed and administered, the Monitoring Team raised concerns of probable under-reporting of medication variances, even though there are signs reporting has improved. Importantly, the medication error report form must be completed appropriately and physicians must be more assertive in assessing and monitoring medication errors and adverse events.

<u>Physical and Nutritional Management</u>

- The Facility had lost the Director of Habilitation Services and five Speech and Language Pathologists (SLPs) to turnover, greatly slowing the pace of improvement in Physical and Nutritional Management and other habilitation services.
- The Physical and Nutritional Management Team (PNMT) was not meeting and did not have any clear center-based policy identifying their roles and responsibilities.
- RSSLC did have a Pneumonia Committee that focused more on systems issues but did not address issues regarding aspects of PNM outside of aspiration pneumonia
- 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. 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.
- 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 Bed elevation is generally assigned and is not clearly based on assessment. Per Director of Habilitation Services, this is an area that will be a focus moving forward.
- 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.

- 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
- Although a new and comprehensive PNM monitoring form had been implemented, monitoring implementation did not cover staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). Monitoring remained highly focused on mealtime. A policy and schedule that will ensure all areas are focused on should be developed.
- 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. Additionally, PNM supports for individuals who are determined to be at an increased level of risk were not provided only 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 an individual or that there was a method in place that helps the supervisors identify staff who have received the needed individualized training.
- The PNM Team did not document progress of individual strategies on a consistent 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.
- Individuals who were enterally nourished had not received an assessment that addressed the medical necessity of the tube and potential pathways to oral (PO) status.

<u>Physical and Occupational Therapy</u>

- While the PT/OT assessments were improved from the previous onsite review, there continued to be some issues related to these.
    - There was a significant amount of health data reported in the assessments, but no evidence of a comparative analysis of health and functional status from the previous year.
    - There was little to no discussion in evaluations of potential for skill acquisition across a variety of areas including eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning.
    - There was no analysis of findings that was based on the data reported compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports.
- Although most areas that should be addressed in these evaluations were addressed, missing from the assessment was a comprehensive section addressing oral care and medication administration.
- Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills.
- There was no evidence that individuals participating in the sensorimotor programs were followed or reviewed by the therapist except during the annual update and even then, there was little to no information provided regarding progress with the program.

- 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. This includes pulled and relief staff.

Dental Services

- The Facility must enhance its ability to incorporated oral health and hygiene issues in the PST process, establish a meaningful database for sedation and behavior management, enhance its ability to communicate and schedule dental services, ensure that quality oral hygiene services are provided at the living areas, and that the use of suction tooth brushes is offered to all Individuals who can benefit from them.

Communication

- Due to staff turnover of five SLPs since the last compliance visit, the Facility employed only three SLPs during this visit. This hampered the Facility's ability to maintain services. . The current ratio for Speech Pathologist to clients was approximately 1 to 128. With the current ratio, RSSLC will find it extremely difficult to make substantial improvements.
- Communication Assessment did not consistently address expansion of current abilities and development of new skills. A new assessment was developed but still had not been implemented at the time of this review.
- Alternative and Augmentative Communication (AAC) devices were not consistently available, utilized, 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. Additionally, all monitoring processes were informal and did not provide clear information regarding detail of monitoring practices as well as frequency in which they should be conducted.
- Direct Care Professionals interviewed were not knowledgeable of the communication programs.

Habilitation, Training, Education, and Skill Acquisition Programs

- The Facility had introduced a variety of processes to improve the quality of skill acquisition programs. At the time of the site visit, however, these efforts had produced inconsistent improvements in those programs.
- Although some improvement was noted in task analysis, the lack of adequate assessments of intelligence, adaptive ability, behavior, and mental illness continued to impede effective teaching
- Skill acquisition training had improved, but the quality remained inconsistent. The implementation of training in the community was introduced, but at the time of the site visit only involved money management programs..

Most Integrated Setting

- The Facility continues 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.

- There were improvements in the CLDP processes, but these continued to be hampered by the deficiencies in assessment practices at the Facility.
- Although the PMM Checklists reviewed were being completed in a timely manner, the process used to complete them was not yet thorough or adequate to be able to state with certainty that the essential and non-essential supports were actually in place. The Post-Move Monitor still needed to provide more detailed documentation of follow-up for identified deficiencies in the provision of supports.
- The Facility had begun to require and document PST review of the results of the PMM visits for each individual, but there was often a significant lapse of time between the PMM visit and the actual review by the PST. It was commendable that the Facility was requiring and tracking PST review, but it should clarify its expectations for the timeliness of the process.

Consent

- The Facility did maintain a list of individuals needing an LAR, but there was still no standardized approach to assessing and determining the actual need for an LAR on an individualized basis that was consistent with commonly accepted professional standards of practice.
- PSTs did not adequately assess decision-making capacities nor develop appropriate action plans to address deficits.
- The HRO had met with the Friends and Family Association to provide an overview of the Guardianship Committee that is expected to be rolled out with the pending Guardianship Policy. The Facility had also posted an announcement on the entrance marquee to solicit interest in becoming a guardian or advocate. There was otherwise little activity toward the solicitation of guardians for individuals during this review period. As part of the Facility undertaking an effective and appropriate large-scale effort to solicit guardians, the Facility should ensure it has an appropriate methodology in place to determine the actual need for guardianship and to educated potential guardians as described above. DADS should complete development of policy, including guidance on such a methodology, as soon as possible.

Recordkeeping and General Plan Implementation

- Although not considered by the Facility to be part of the Unified Record, the Share drive provided the potential for accessibility to assessments by all members of the PST. Unfortunately, filing of assessments was not consistently done prior to the PSP meeting, so this system was not yet fully useable.
- This audit process itself, although implemented and revised recently, could be considered to meet the auditing requirements of this provision. However, the process for requiring corrections for errors in the record was informal. As reported by the Director of Medical Records and the Unified Records Coordinators, requests for correction were mostly made verbally to the person who needed to make the correction or to a supervisor. There was not yet a process to follow up to ensure corrections were made.
- A process to assess use of records in making decisions about treatment, services, and interventions was planned but not yet implemented. Using a similar process and instrument, the Monitoring Team gathered information that confirmed, for a sample of clinicians, that documentation could usually be found and that staff perceived they used information from

other disciplines in making decisions. Nevertheless, as reported in several sections of this report, there were instances in which staff did not use or could not find information in the record but instead made decisions based on anecdotal information; furthermore, problems identified in Section F indicate that data that were available were not necessarily accurate and useful.

- The State and Facility had developed or revised numerous policies. This process is continuing. Many of the policies were recently implemented, and implementation was not yet complete or entirely accurate. The Facility had not developed processes for the dissemination of policies and training of staff on new or revised policy requirements.

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. RSSLC Plan of Improvement (POI) 4/18/11 2. DADS Policy #001: Use of Restraint 8/31/09 3. DADS Policy #015: Dental Services 8/17/10 4. RSSLC Policy J.1: Use of Restraint 3/1/11 5. RSSLC Policy J.2: Completing the Restraint Checklist/Monitoring Restraint 3/1/11 6. RSSLC Policy J.4: Using Restrictive Supports to prevent Involuntary Self-Injury 3/1/11 7. RSSLC Policy J.5: Using Restraint to Provide Postural Support 3/1/11 8. RSSLC Policy J.7: Completing/Routing Restraint Checklist 10/29/03 9. RSSLC Policy J.11: Using Sedation for Medical/Dental Appointments (3/10/10) 10. RSSLC Policy J.13 Implementing Dental Treatment Support Plan 2/4/08 11. PMAB Training Curriculum 12. Restraint Reduction Team Meeting minutes for 12/30/10, 1/27/11, 2/24/11, and 3/30/11 13. Restraint Checklist and related documentation for physical restraints for Individuals #25 (1/16/11), #267 (12/16/10), #58 (11/8/10), #630 (3/28/11), #448 (1/7/11), # 445 (2/1/11), and #448 (1/7/11) 14. Restraint Checklist and related documentation for chemical restraints for Individuals #361 (3/31/11), #798 (2/8/11), #58 (10/24/10, and #448 (1/7/11) 15. Restraint Checklist and related documentation for medical restraints for Individuals #551 (10/25/10), #296 (3/28/11), #199 (10/4/10), #598 (12/7/10 and 3/8/10), #555 (11/1/10 and 1/5/11), #353 ((1/3/11), #254 (10/14/10), #369 (11/10/10), and #399 (12/21/10) 16. Restraint Checklist and related documentation, including Safety Plans, for mechanical restraints for Individuals #219, #162, and #320 17. State report "Percent of All Employees Completing Courses of Training Program." 5/1/11 18. Restraint related monitoring/QA forms and reports 19. List of individuals for whom restraint is prohibited (undated) 20. List of individuals with mechanical restraints for protective reasons (undated) 21. Facility restraint log 10/25/10 to 3/17/11 22. List of individuals with a Safety Plan 3/28/11 23. Dental Sedation Log October 2010 to March, 2011 24. Dental Support Plans and implementation documentation for Individuals #321, #223, #553, and #361 25. Facility Restraint Trend Analysis for period ending 4/30/11 26. Incident Management Team minutes for 4/4/11, 3/7/11, 4/11/11, and 3/14/11 27. List of staff approved as Restraint Monitors (undated-document request II.19) 28. Restraint Monitors training transcripts (15) 29. Direct Care Professional (DCP) training transcript (25)

	People Interviewed: 1. Joan Poenitzsch, Director of Quality Assurance 2. Shannon Seale, Director of Residential Services 3. Billie DeJean, Psychologist 4. Reuben Muhammad, Incident Management Coordinator 5. William Eckenroth, PhD, Director of Behavioral Services 6. Carol Agu, QMRP Services Director 7. Ten Direct Care Professionals **Meetings Attended/Observations:** 1. Incident Management Team Meeting (IMRT) 5/2/11 2. HRC meeting 5/5/11 3. Four Rivers Unit Morning Meeting 5/5/11 4. Quality Assurance/Quality Improvement (QA/QI) Council 5/3/11 5. Administrative Review Team 5/3/11 6. PST meetings for Individual #52 5/2/11 7. Active Treatment meeting 5/3/11 8. Meeting with QA Department Staff 5/4/11
	Facility Self-Assessment: The RSSLC's Plan of Improvement (POI) reported that the Facility was not in compliance with any provision of the Settlement Agreement. The Monitoring Team agrees with this self-assessment. The POI reported that restraint policies had been revised to comport with State policy and these changes were implemented on 12/1/10; however, the policy documents provided to the Monitoring Team indicate the policy revisions occurred 3/1/11 and, as the reporting in this section will describe, there are still substantial variations between State (and now RSSLC) policy and administrative and clinical implementation issues. This is most apparent by the lack of use of the State required Face-to-Face Assessment/Debriefing document. The POI reported that a process has been put in place to self-identify errors and omissions in documentation. This process should lead to improved program performance.
	Summary of Monitor's Assessment: The RSSLC's Plan of Improvement (POI) reported that the Facility was not in compliance with any provision of the Settlement Agreement. The Monitoring Team agrees with this self-assessment. Since the last review the RSSLC revised its primary restraint policy J.1 to mirror the State policy on restraint. Some of the supplemental restraint policies need revision, as they do not always reflect definitions and terms that are consistent with the primary policy. Crisis intervention restraint use at RSSLC has remained relatively constant over the last 15 months. The FY11 Trend Analysis Reports shows the quarterly use of restraint ranging from 41 to 47, an average of 14.7 per month. These data are for the 15 month period beginning in December, 2009 and ending in February,

	2011. The number of restraints reported for March 2011 was 15, which was consistent with the average over the last 15 months. The Trend Analysis Report includes data elements for the report month including the type of restraint, location of restraint, restraint use by home and by residential unit, restraint use by shift and day of the week, restraint use by time of day, and the behavioral cause of restraint use. None of these data are trended over time, which restricts their usefulness in identifying anything appearing to need special attention or focused intervention by clinical staff. The Trend Analysis Report needs to track more data elements over time, at least for the equivalent time period the summary data is tracked. In reviewing data for March, 2011 (the only data in the Trend Analysis Report which includes the data elements described in the previous paragraph) it is reported that eight of the 15 restraints (53%) were chemical restraints and four (27%) were horizontal (i.e. individual taken down to the floor) restraints. Use of restraint can indicate the absence of effective behavioral treatment planning for the individuals involved in these restraints. Behavioral practices at the RSSLC are discussed in detail in Section K of this report. Significant deficient practices presented in Section K may affect the use of restraint at the RSSLC. These issues need to be effectively addressed in order to reduce the use of restraint at the RSSLC, especially the use of chemical restraint. The Monitoring Team found many instances of incomplete or incorrect documentation of restraint use. None of the restraint records included use of the required Face-to-face Assessment/Debriefing document required by State policy and many did not include an alternative document used by the RSSLC. Additional staff training is needed. The Facility had initiated a process to audit restraint records. The Monitoring Team could not validate that the five minute release time for mechanical protective restraints was occurring. Only one of the staff listed as a Restraint Monitor on Restraint Checklists was on the list of approved Restraint Monitors provided to the Monitoring Team. Administrative staff acknowledged there were issues with the number of, and training of, restraint monitors and, as a result, the Facility had decided to limit the number of staff who could serve as restraint monitors. In the future, unit behavior analysts and psychology assistants will be designated as primary restraint monitors. When these staff are unavailable a limited number of other staff would serve as restraint monitors, including trained Unit RNs, Campus Coordinators and Campus Administrators. Medical staff has not been consistently establishing restraint monitoring protocols for chemical crisis intervention restraint and medical restraint specific to each episode of restraint. Nursing staff have not been consistently monitoring individuals in chemical crisis restraint or medical restraint correctly largely due to the absence of doctor ordered specific monitoring protocol. Additionally, nursing staff have not consistently been monitoring individuals in restraint post-release in accordance with policy.

	The process for review of individual restraint episodes needs substantial improvement including a more clinical orientation. Direct Care Professionals interviewed by the Monitoring Team demonstrated insufficient knowledge in restraint policy and application, and additional training is needed. In 60% of the crisis intervention restraints reviewed, the restraint documentation reports that the individual's Positive Behavior Support Plan (PBSP) and Safety Plan (SP) were not implemented in an attempt to avoid the need for restraint. This suggests to the Monitoring Team that restraint may be used for the convenience of staff and not in a clinically justifiable manner.

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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.	In its Plan of Improvement (POI) the RSSLC reported that it was not in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs. The following facility policies that govern the use of restraint were reviewed by the Monitoring Team: 1. RSSLC Policy J.1: Use of Restraint 3/1/11 2. RSSLC Policy J.2: Completing the Restraint Checklist/Monitoring Restraint 3/1/11 3. RSSLC Policy J.4: Using Restrictive Supports to prevent Involuntary Self-Injury 3/1/11RSSLC 4. RSSLC Policy J.5: Using Restraint to Provide Postural Support 3/1/11 5. RSSLC Policy J.7: Completing/Routing Restraint Checklist 10/29/03 6. RSSLC Policy J.11: Using Sedation for Medical/Dental Appointments (3/10/10) 7. RSSLC Policy J.13 Implementing Dental Treatment Support Plan 2/4/08 Policy J.1 mirrors the State policy on restraint. The other RSSLC restraint policies provide additional facility specific policy and operational guidance. Crisis intervention restraint use at RSSLC remained relatively constant over the last 15 months. The FY11 Trend Analysis Reports showed the quarterly use of restraint ranging from 41 to 47, an average of 14.7 per month. These data were for the 15 month period beginning in December, 2009 and ending in February, 2011. The number of restraints reported for March 2011 was 15 which was consistent with the average over the last 15 months. The Trend Analysis Report includes data elements for the report month including the type of restraint, location of restraint, restraint use by home and by residential unit, restraint use by shift and day of the week, restraint use by time of day, and the behavioral cause of restraint use. None of these data were trended over time, which restricts their	Noncompliance

#	Provision	Assessment of Status	Compliance
		usefulness in identifying anything appearing to need special attention or focused intervention by clinical staff. The Trend Analysis Report needs to track more data elements over time, at least for the equivalent time period the summary data is tracked. In reviewing data for March, 2011 (the only data in the Trend Analysis Report which included the data elements described in the previous paragraph), it is reported that eight of the 15 restraints (53%) were chemical restraints and four (27%) were horizontal (i.e. individual taken down to the floor) restraints. Both are considered highly restrictive and can indicate the absence of effective behavioral treatment planning for the individuals involved in these restraints. Behavioral practices at the RSSLC are discussed in detail in Section K of this report. Significant deficient practices are presented in Section K which impacts the use of restraint at the RSSLC. These issues need to be effectively addressed in order to reduce the use of restraint at the RSSLC. RSSLC Policy J.1: Use of Restraint, RSSLC Policy J.11: Using Sedation for Medical/Dental Appointments, and RSSLC Policy J.13 Implementing Dental Treatment Support Plan 2/4/08 also are directed at compliance with the requirements of the SA. Documentation review and interviews by the Monitoring Team suggest that staff who should understand these policies, primarily medical and nursing staff, did not, or if they did they did not consistently use the procedures in these policies correctly. For example, policy requires that the Restraint Checklist and Face-to Face Assessment/Debriefing (FFAD) be used in all instances of restraint use. The policy (both State and RSSLC) does not exclude medical restraints from this requirement. In its review of medical/dental restraint documentation the Monitoring Team did not find a Restraint Checklist or FFAD in any of the 12 restraint episodes for which the Facility was asked to produce documentation. The Monitoring Team assembled four samples of restraint use at the RSSCLC. The source document used for these samples was the listing of restraints used since the last review which was provided in response to the monitoring team's pre-visit document request. This included: 1. Physical Restraints: The sample of 10 restraints involving six individuals, representing 20% of physical restraint records, included Individuals #25, #267, #58, #630, #448 (3x), and #445 (3x). This sample will be labeled Sample C.1.a. 2. Mechanical Protective Restraints: The sample of three restraints involving three individuals, representing 20% of restraint records, included Individuals #219, #162, and #320. Each had multiple instances of restraint use and all three had a safety plan. This sample will be labeled Sample C.1.b. 3. Chemical Restraints: The sample of four restraints involving four individuals, representing 20% of restraint records, included Individuals #361, #798, #58, and #448. This sample will be labeled Sample C.1.c. 4. Medical Restraints: The sample of 11 restraints involving nine individuals,	

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		representing 10% of restraint records, included Individuals #551, #296, #199, #598, #555, #353, #254, #369, and #399. This sample will be labeled Sample C.1.d. To assist in the review of restraint documentation the Monitoring Team asked that the Facility prepare a file for each restraint episode selected for the above samples. This was to include the Restraint Checklist, Face-to-Face Assessment/Debriefing, any medical orders, any physician specified monitoring schedule, any standard facility protocol for monitoring restraint, documentation of review activity, and any other information that might be helpful in understanding the circumstances associated with the restraint use such as the individual's Positive Behavior Support Plan. The expectation of the Monitoring Team was that the Facility would provide all documentation it had that would demonstrate compliance with this provision of the Settlement Agreement (SA). <u>Prone Restraint</u> Based on Facility policy review, prone restraint is prohibited. Based on review of restraint records, restraint reduction committee minutes, and minutes of the Incident Management Team (IMRT), no clear use of prone restraint was identified or the subject of any discussion in meeting minutes. Nevertheless, four of the 15(27%) restraints in March, 2011 were horizontal side-lying restraint which can inadvertently result in the individual being in a prone position even if only for a brief moment. Most DCPs interviewed did not know what prone restraint was. None responded correctly when asked "do you know what prone restraint is." When it was described by the Monitoring Team nine of the 10 staff interviewed knew it was prohibited. One staff person never acknowledged that prone restraint was prohibited. This suggests a need for additional training to ensure implementation of side-lying restraint techniques do not inadvertently include the individual being in a prone position during any phase of the restraint implementation. <u>Other Restraint Requirements</u> Based on the document review, the Facility policies state that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records (to include all the information identified above that the Monitoring Team asked the Facility to prepare)were reviewed to determine if restraint implementation was occurring in accordance with written policies and procedures for Sample C.1.a (physical restraints). The following are the results of this review: 1. In three of the 10 records (30%), there was documentation showing that the individual posed an immediate and serious threat to self or others. Four restraint	

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		files (representing seven restraint episodes) prepared by the Facility did not include a Face-to-Face Assessment/Debriefing (FFAD). Without this document the Monitoring Team does not have sufficient information to determine compliance with this requirement. The FFAD was not present for Individuals #448 (3x), #267, #25, #630 and #58. The FFAD document used by the RSSLC, entitled "Emergency/Contingent Restraint Debriefing", was outdated and did not contain the all data items required by this document in State policy. This inhibits a complete review of the restraint episode. The information on the Restraint Checklist was generally descriptive enough to believe the person posed an immediate threat but supplemental information in the FFAD is essential to confirm this belief. 2. In six (60%) of the 10 records there was documentation to suggest restraint may have been used for the convenience of staff. Individuals #630, #448 (3x), and #267 had a Positive Behavior Support Plan (PBSP) and Safety Plan (SP). The Restraint Checklist for each of these five restraints reported that neither the PBSP nor Safety Plan was implemented prior to the use of restraint. This would suggest that the use of restraint without following the approved behavior management strategies in the PBSP and SP may have occurred for the convenience of staff. Individual #25 had a PBSP. The Restraint Checklist reported that the PBSP was not implemented prior to the use of restraint. This would suggest that the use of restraint without following the approved behavior management strategies in the PBSP may have occurred for the convenience of staff. Even if the individuals presented an imminent risk of harm, the lack of implementation of safety plans and the PBSP indicate the possibility that the risk might have been mitigated and restraint avoided if programs designed by the PST were followed. The Monitoring Team recognizes that this lack of implementation of planned interventions could have occurred for other reasons; nevertheless, the Facility did not demonstrate that the plans had been implemented, nor did the Facility have data to identify whether the plans were effective in minimizing use of restraint. 3. In six (60%) of the 10 records there was documentation to suggest restraint may not have been used in a clinically justifiable manner. As reported above, Individuals #630, #448 (3x), and #267 had Positive Behavior Support Plans (PBSP) and Safety Plans (SP). The Restraint Checklist for each of these five restraints reported that neither the PBSP nor Safety Plan was implemented prior to the use of restraint. PBSPs and SPs are developed by clinical staff to ensure, in part, behavior management, including the use of restraint, is done in a clinically justifiable manner. The use of restraint without following the approved behavior management strategies in the PBSP and SP would suggest to the Monitoring Team that the management of the behavior that resulted in the use of restraint did not occur in a clinically justifiable manner. 4. In six (60%) of the 10 records there is documentation to suggest restraint may have been used prior to implementing a graduated range of less restrictive measures.	

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		Individuals #630, #448 (3x), and #267 have Positive Behavior Support Plans (PBSP) and Safety Plans (SP). The Restraint Checklist for each of these five restraints reports that neither the PBSP nor Safety Plan was implemented prior to the use of restraint. PBSPs and SPs are developed by clinical staff to ensure, in part, a graduated range of less restrictive techniques are identified as being potentially helpful in dealing with problematic behavior which may lead to restraint. The use of restraint without following the approved behavior management strategies in the PBSP and SP would suggest to the Monitoring Team that use of a graduated range of less restrictive measures did not occur prior to the use of restraint. 5. There were some cases in which actions were taken to attempt to avoid restraint, including following instructions in the PBSP. Several restraint checklists indicated in narrative form the actions taken to try to avoid restraint. This was the case with Individual #455 who was restrained three times on the same day. Both the Restraint Checklist and the FFAD report multiple steps taken to avoid restraint use including prompting replacement behavior, using the interventions in the PBSP, verbal prompts and redirection, removal of dangerous objects, trading out staff, moving furniture, and changing the environment. 6. Eight of ten (80%) records contained information validating Personal Support Team (PST) and Unit Morning Meeting review of the restraint episode. This was documented in a Personal Support Plan Addendum (PSPA) and in Unit Morning Meeting Minutes. Documentation provided for the restraint of Individual #25 did not include a PSPA to validate PST review of the restraint. Documentation provided for the restraint of Individual #58 did not include IMRT minutes to validate review of the restraint. Restraint records (to include all the information identified above that the Monitoring Team asked the Facility to prepare)were reviewed to determine if restraint implementation was occurring in accordance with written policies and procedures for Sample C.1.b (mechanical protective restraints). The following are the results of this review: 1. RSSLC had14 individuals using mechanical restraints for protective reasons. The Monitoring Team asked for, and was provided, with relevant documentation for three. The Monitoring Team did not have an opportunity to personally observe any of the three individuals being restrained during this review. 2. All three individuals had a Safety Plan as required by policy. 3. Individual #320 had the following mechanical restraints in use: neck brace, protective helmet, wrist restraints, and mittens. The Safety Plan called for release from restraint every 55 minutes for 5 minutes. It also required circulation checks every 30 minutes. Documentation of both was to be recorded on a Restraint Checklist. From the documentation submitted to the Monitoring Team it appears a Restraint Checklist was to be prepared each shift. In reviewing the Restraint	

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		Checklists for 4/5/11, 4/12/11, and 4/19/11 (randomly selected by the Monitoring Team), it was evident circulation checks were well documented. It was not possible to determine if the required 55 minute release occurred. Staff completing the checklist frequently used a code "H" which was not included in the code options offered on the form. If this code was meant to indicate a five minute release its use was inconsistent. The Monitoring Team could not validate that the five minute release time was occurring. 4. Individual #162 had the following mechanical restraints in use: one pieceunitard and a denim clothing protector. The Safety Plan calls for the individual to not wear the unitard for one hour each day. Compliance with this could not be determined because most of the Restraint Checklists provided to the Monitoring Team were not completed correctly and no other data were provided. 5. Individual #219 had the following mechanical restraints in use: wheelchair seat belt. The Safety Plan calls for the individual to not wear the seatbelt one hour a day. Compliance with this could not be determined because most of the Restraint Checklists provided to the Monitoring Team were not completed correctly and no other data were provided. Restraint records (to include all the information identified above that the Monitoring Team asked the Facility to prepare) were reviewed to determine if restraint implementation was occurring in accordance with written policies and procedures for Sample C.1.c (chemical restraint). The following are the results of this review: 1. Two of four (50%) files contained a FFAD; however, the FFAD form was outdated and did not contain all data items currently required by State policy. This inhibits a complete review of the restraint episode. The most apparent deficiency is the absence of the required post restraint clinical review by the psychiatrist and the pharmacist. 100% of the sample did not have this required review. 2. In two of the four records (50%), there was documentation showing that the individual posed an immediate and serious threat to self or others. Two restraint files prepared by the Facility did not include a Face-to-Face Assessment/Debriefing (FFAD) and the other two did not contain complete information as noted above. Without this document the Monitoring Team does not have sufficient information to determine compliance with this requirement. The FFAD was not present in any form for Individuals #361 and #798. The information on the Restraint Checklist was generally descriptive enough to believe the person posed an immediate threat but supplemental information in the FFAD is essential to confirm this belief. 3. In three (75%) of the four records there was documentation to suggest restraint may have been used for the convenience of staff. Individuals #448 and #798 had a Positive Behavior Support Plan (PBSP) and Safety Plans (SP). The Restraint Checklist for each restraint reported that neither the PBSP nor Safety Plan was implemented prior to the use of restraint. This would suggest that the use of restraint without	

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		following the approved behavior management strategies in the PBSP and SP may have occurred for the convenience of staff. Individual #58 has a PBSP. The Restraint Checklist reports that the PBSP was not implemented prior to the use of restraint. This would suggest that the use of restraint without following the approved behavior management strategies in the PBSP may have occurred for the convenience of staff. Even if the individuals presented an imminent risk of harm, the lack of implementation of safety plans and the PBSP indicate the possibility that the risk might have been mitigated and restraint avoided if programs designed by the PST were followed. As noted above in the discussion regarding records of use of physical restraint, the Monitoring Team recognizes that this lack of implementation of planned interventions could have occurred for other reasons; nevertheless, the Facility did not demonstrate that the plans had been implemented, nor did the Facility have data to identify whether the plans were effective in minimizing use of restraint. 4. In three (75%) of the four records there was documentation to suggest restraint may not have been used in a clinically justifiable manner. Individuals #448 and #798 had a Positive Behavior Support Plan (PBSP) and Safety Plan. The Restraint Checklist for each restraint reported that neither the PBSP nor Safety Plan was implemented prior to the use of restraint. PBSPs and SPs are developed by clinical staff to ensure, in part, behavior management, including the use of restraint, is done in a clinically justifiable manner. The use of restraint without following the approved behavior management strategies in the PBSP and SP would suggest to the Monitoring Team that the management of the behavior that resulted in the use of restraint may not have occurred in a clinically justifiable manner. 5. In three (75%) of the four records there was documentation to suggest restraint may have been used before a graduated range of less restrictive measures had been exhausted. Individuals #448 and #798 have a Positive Behavior Support Plan (PBSP) and Safety Plan. The Restraint Checklist for each restraint reports that neither the PBSP nor Safety Plan was implemented prior to the use of restraint. PBSPs and SPs are developed by clinical staff to ensure, in part, a graduated range of less restrictive techniques are identified as being potentially helpful in dealing with problematic behavior which may lead to restraint. The use of restraint without following the approved behavior management strategies in the PBSP and SP would suggest to the Monitoring Team that a graduated range of less restrictive measures did not occur prior to the use of restraint. 6. All four (100%) records contained a physician order for the chemical restraint. 7. All four (100%) records contained information validating Personal Support Team (PST) and Unit Morning Meeting review of the restraint episode. This was documented in a Personal Support Plan Addendum (PSPA) and in Unit Morning Meeting Minutes. The PSPAs reviewed documented the circumstance of the restraint use but did not usually contain thoughtful clinical considerations.	

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		Restraint records (to include all the information identified above that the Monitoring Team asked the Facility to prepare)were reviewed to determine if restraint implementation was occurring in accordance with written policies and procedures for Sample C.1.d (medical restraint). The following are the results of this review: 1. None (0%) of the nine medical restraints reviewed contained documentation that a physician had specified a monitoring schedule or the type of monitoring that should occur. 2. Seven (78%) of the nine medical restraints reviewed contained documentation that a nurse had specified the type of monitoring and the schedule for monitoring using one of two forms: 1) Medical Monitoring of Dental Sedation (10/20/10), or, 2) Medical Monitoring of an Episode of Acute Illness/TIVA/Sedation (6/20/06). By policy the type and schedule of monitoring is to be specified by a physician, not a nurse. Documentation that the specified monitoring occurred was variable and difficult to understand. In no case did the monitoring relate to the specific data items required. Most often general terms such as "sleeping, "talkative," "hyper," or "awake" were noted. Two different monitoring forms were in use. One dated 6/20/06 included a column for the date and time of the monitoring, the condition of the individual, actions taken, and signature. The other form dated revised 10/20/10 contained the same information but deleted the date column. This made it impossible to cross reference the monitoring form to the specific use of medical restraint.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. The restraint records involving the six individuals in Sample C.1.a were reviewed. Of these, three of the individuals (50%) had Safety Plans that described the circumstances for the use of restraint, including release criterion. For the three individuals who had Safety Plans, restraint records for one (33%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Safety Plan. Examples where documentation showed that restraint release was not in accord with the Safety Plan specifications include: 1. Individual #448's Safety Plan included the following release criteria: "to be released he must not attempt to hit staff for at least 60 seconds or when the fixed amount of time (3 minutes) for restraint as part of his safety plan is met. Whichever comes first." This individual was restrained three times on 1/7/11. Insufficient information	Noncompliance

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		was included on the Restraint Checklist and Emergency/Contingent Restraint Debriefing for the Monitoring Team to validate the release criterion was applied in each restraint. For example, for the restraint that occurred at 8:52am the release criteria code on the Restraint Checklist is P (released immediately because no longer an immediate and serious risk of harm to self/others). There is no information on the checklist or debriefing form to suggest whether the 60 second criterion was observed or met. In fact, the Restraint Checklist indicated the restraint began at 8:52am and the Individual was "agitated: yelling, cursing, threatening." The restraint release time was 8:53am – a one minute restraint. If the Individual immediately calmed down when restrained it is possible the 60 second criterion was observed. It is just as likely the Individual calmed down during or at the end of the one minute period and was immediately released (as the code on the Restraint Checklist would indicate) and the 60 second criterion was not observed, From the information presented on the Restraint Checklist and Debriefing form there is no way to be certain. 2. Individual #630's Safety Plan included the following release criteria: "to be released he must be calm and not self-injurious or aggressive to others for at least 60 seconds or when the fixed amount of time (10 minutes) for restraint as part of his safety plan is met. Whichever comes first." There was no information on the Restraint Checklist to indicate the 60 second criterion was observed. No debriefing form was provided to the Monitoring Team. The release criteria code on the Restraint Checklist was P (released immediately because no longer an immediate and serious risk of harm to self/others). This is insufficient to conclude the 60 second criterion was observed. An example where documentation showed that restraint release was in accord with the Safety Plan specifications is the restraint of Individual #267. The Individual's Safety Plan stated "attempt to release (name) from restraint when she is no longer a danger to self/others or when the fixed amount of time (15 minutes) for restraint as part of his safety plan is met. Whichever comes first." [Sic--Note that this Safety Plan referred to "she" and "his."] The release criteria code on the Restraint Checklist is P (released immediately because no longer an immediate and serious risk of harm to self/others). The Facility did not provide a Debriefing form so no additional information was available to the Monitoring Team. For the three individuals who did not have Safety Plans, two (67%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Examples showing documentation that the individual was released when he/she was no longer a danger to self or others included: 1. For Individual #455 the Restraint Checklist for all three restraints indicated release code P – "released immediately because no longer an immediate and serious risk of harm to self/others." 2. For Individual #25 the Restraint Checklist indicated release code P – "released	

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		immediately because no longer an immediate and serious risk of harm to self/others." The release code for Individual #58 was Q (other – "released") and an event code 5 (other "calm"). The Facility did not provide a Debriefing form so no additional information was available to the Monitoring Team.	
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 Monitoring Team reviewed the following policies: 1. RSSLC Policy J.1: Use of Restraint 3/1/11 2. RSSLC Policy J.2: Completing the Restraint Checklist/Monitoring Restraint 3/1/11 3. RSSLC Policy J.4: Using Restrictive Supports to Prevent Involuntary Self-Injury 3/1/11 4. RSSLC Policy J.5: Using Restraint to Provide Postural Support 3/1/11 5. RSSLC Policy J.7: Completing/Routing Restraint Checklist 10/29/03 6. RSSLC Policy J.11: Using Sedation for Medical/Dental Appointments 3/10/10 7. RSSLC Policy J.13: Implementing Dental Treatment Support Plan 2/4/08 Policy J.1 mirrors the State policy on restraint. The other RSSLC restraint policies provide additional facility specific policy and operational guidance. These additional policies were not always aligned with Policy J.1, which mirrors the State policy. For example, Policy J.7 Completing/Routing Restraint Checklist had not been revised since 2003. Some of the instructions in the policy were clearly incorrect. For example, the observation and release codes noted in the policy are not the same as those now used in the standard checklist that is part of Policy J.1. Multiple examples of issues with policy implementation are presented in sections C.1 and C.2 and will not be repeated in this section. Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: 1. Policies governing the use of restraint 2. Approved verbal and redirection techniques 3. Approved restraint techniques 4. Adequate supervision of any individual in restraint None of the RSSLC restraint policies include specific classes, by reference number, required of staff. In the absence of a policy defining required training, the Monitoring Team checked 25 staff training records (selected by picking the first name of a direct care professional MRA on each printout page of the list of employees) to validate completion of the following courses: 1. RES0105 Restraint: Prevention and Rules for Use at MR Facilities	Noncompliance

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		2. RES0110 Applying Restraint Devices 3. PMA0320 – PMAB Basic 4. PMA0400- PMAB Restraint 5. PMA0700 –PMAB Prevention 6. PBS0100 – Positive Behavior Support The Monitoring Team used this sample of 25 direct care staff, referred throughout the report as Sample C.2, to determine the following: For training class RES0105 Restraint: Prevention and Rules for Use at MR Facilities 22 of the 25 (88%) had completed the training within the last 12 months. For training class RES0110 Applying Restraint Devices 24 of the 25 (96%) had completed the training within the last 12 months. 1. For training class PMA0320 – PMAB Basic 23 of the 25 (92%) had completed the training within the last 12 months. 2. For training class PMA0400 – PMAB Restraint 23 of the 25 (92%) had completed the training within the last 12 months. 3. For training class PMA0700 – PMAB Prevention 23 of the 25 (92%) had completed the training within the last 12 months. 4. For training class PBS0100 – Positive Behavior Support 24 of the 25 (96%) had completed the training within the last 12 months. The Monitoring Team also reviewed a State report "Percent of All Employees Completing Courses of Training Program." This report indicated the following completion rates for RSSLC employees: 1. 99% RES0105 Restraint: Prevention and Rules for Use at MR Facilities 2. 100% RES0110 Applying Restraint Devices 3. 100% PMA0320 – PMAB Basic 4. 100% PMA0400- PMAB Restraint 5. 100% PMA0700 –PMAB Prevention 6. 99% PBS0100 – Positive Behavior Support The compliance rates derived from the sample conducted by the Monitoring Team are in all cases lower than the compliance rates indicated in the State report. RSSLC may wish to conduct its own employee sample and/or review its data entry process for the State report to ensure information reported into the State database is accurate. When documentation has errors and does not demonstrate for all restraints that policy was followed (as noted in Provision C1), another way to determine whether training on	

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		policies has been competency-based and whether staff remain competent is to determine whether they can explain the policies. Based on an interview of 10 staff responsible for the provision of supports to individuals, in which they were asked to tell the Monitoring Team about the policies covering restraint: 1. Five (50%)were able to accurately describe policies governing the use of restraint 2. Six (60%) were able to accurately describe approved verbal and redirection techniques 3. Six (60%) were able to accurately describe approved restraint techniques 4. One (10%)was able to accurately a describe adequate supervision of any individual in restraint Staffs' inability to clearly and accurately describe some of the fundamental restraint policy requirements may indicate a need for further training to ensure competent implementation of restraint procedures. All 10 staff interviewed had been directly involved in using restraints within the last six months. The Monitoring Team was able to solicit better responses after asking leading follow-up questions. Because these staff had recently been involved in restraint application the Monitoring Team expected clearer articulation to straightforward questions and remain concerned that staff did not have a thorough understanding of the policy regarding use of restraint (and thus could violate that policy inadvertently). As noted in Section C.1 40% of the restraint records reviewed for physical restraint and 25% of the restraint records reviewed for chemical restraint showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	
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	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. The RSSLC Policy J.1: Use of Restraint states that restraint, other than medical restraints, can only be used for crisis intervention. Based on a review of 10 physical, four chemical, and three mechanical protective restraints (Samples C.1.a, C.1.b, and C.1.c), in 16 (94%) there was evidence documenting that restraint was used as a crisis intervention. On the restraint checklist for Individual #58 an outdated Restraint Checklist (dated 9/1/09) was used and did not contain a "crisis intervention" option in the type of restraint section of the checklist. This is one example of use of a form that is not current. Another example is the frequent use of the Emergency/Contingent Restraint Debriefing form (dated 4/06) rather than the State	Noncompliance

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	eliminate the need for restraint.	policy required Face-to-Face Assessment/Debriefing form. The forms approved in the State policy on restraint are organized in such a manner as to record all necessary information to measure compliance with the SA.RSSLC needs to purge all outdated forms and take steps to ensure only currently approved forms are in use at the Facility. The RSSLC debriefing form suggested the restraint was a crisis intervention but it was not documented as such on the restraint checklist. The Restraint Checklist is considered by the Monitoring Team to be a primary source of restraint documentation. It is imperative it be complete and accurate. The Monitoring Team was provided with a list of individuals for whom restraint was prohibited. In comparing this list with the log of restraints the Monitoring Team identified one person on the "do not restrain" list who was restrained. Individual #798 was chemically restrained on 2/8/11 even though this individual was on the list provided to the Monitoring Team of individuals who are not to be restrained. Documentation provided by the Facility relevant to the 17 non-medical (crisis intervention) restraint records (Samples C.1.a, C.1.b, and C.1.c) reviewed did not contain information about whether a physician had provided a medical order stating whether the individual could or could not be restrained, or if there were limitations on the type of restraint that could be used. Therefore, the Monitoring Team could not determine whether any restraints used were prohibited by medical orders for the three samples. The Monitoring Team had asked that the Facility prepare a file for each restraint episode selected for the sampled restraint episodes. This was to include the Restraint Checklist, Face-to-Face Assessment/Debriefing, any medical orders, any physician specified monitoring schedule, any standard facility protocol for monitoring restraint, documentation of review activity, and any other information that might be helpful in understanding the circumstances associated with the restraint use such as the individuals Behavior Support Plan. The absence of some relevant documentation in the files prepared by the RSSLC does not allow the Monitoring Team to adequately assess whether physicians regularly assess whether restraint should be limited or prohibited prior to implementation of restraint for each individual who is restrained. Although these individuals were not on the list provided to the Monitoring Team of individuals who are not to be restrained, that list is not routinely available to the staff who might be involved in a restraint. It is essential that the PST and staff providing supports and services have all information needed to make decisions about restraint use. Physician orders for crisis intervention restraint which is not part of a SPCI are required by State policy. Three of the 17 restraints in Sample C.1.a, C.1.b, and C.1c involved individuals without a SP. Physician orders were provided to the Monitoring Team in two instances (67%). These were for Individuals #455 and #58. Physician orders were not provided for Individual #25.	

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		Medical and dental support plans had been developed for many individuals; however, documentation of implementation led the Monitoring Team to conclude implementation is not occurring as planned. For example: • Individual #321 had a medical support plan that was put in place in September, 2010. The Monitoring Team requested data sheets for January, February, and March 2011. Data sheets were not provided for February or March leading the Monitoring Team to conclude the plan had not been implemented during this time period. • Individual #223 had a dental support plan that was put in place on January 6, 2011. The Monitoring Team requested data sheets for January, February, and March 2011. From the documentation provided it appears this plan was first implemented on 3/24/11. • Individual #361 had a dental support plan that was put in place in November, 2010. The Monitoring Team requested data sheets for January, February, and March 2011. No data sheets were provided leading the Monitoring Team to conclude the plan had not been implemented.	
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	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. Review of Facility training documentation showed that there were adequate training curricula on the application and assessment of restraint. The Facility provided a list of 59 names of staff authorized to perform the duties of a restraint monitor. Conducting the FFAD is one of the primary duties of a restraint monitor. The following classes were identified as being required if someone was to act as a restraint monitor, and therefore conduct FFADs. 1. ABU0100 Abuse and Neglect 2. PMA0320 PMAB Basic 3. PMA0400 PMAB4: Restraint 4. PMA0700 PMAB7: Prevention 5. CPR0100 CPR Basic 6. RES0105 Restraint: Prevention and Rules for Use at MR Facilities 7. RES0110 Applying Restraint Devices 8. UNU0100 Unusual Incidents 9. PBS0100 Positive Behavior Support 10. RES0115 Restraint: Prevention and Rules for Use at MR Facilities	Noncompliance

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	order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	The training records of 15 of the 59 (25%) staff designated as restraint monitors were selected for review. The results of this review is: 1. ABU0100 Abuse and Neglect – 13 of 15 (87%) had completed this training within the last 12 months. 2. PMA0320 PMAB Basic - 15 of 15 (100%) had completed this training within the last 12 months. 3. PMA0400 PMAB4: Restraint - 11 of 15 (73%) had completed this training within the last 12 months. 4. PMA0700 PMAB7: Prevention - 15 of 15 (100%) had completed this training within the last 12 months. 5. RES0105 Restraint: Prevention and Rules for Use at MR Facilities - 12 of 15 (80%) had completed this training within the last 12 months. 6. RES0110 Applying Restraint Devices- nine of 15 (60%) had completed this training within the last 12 months. 7. UNU0100 Unusual Incidents-13 of 15 (87%) had completed this training within the last 12 months. 8. PBS0100 Positive Behavior Support-15 of 15 (100%) had completed this training within the last 12 months. Ten of the 15 (67%) restraint monitors in the sample were not current on completion of required training course and therefore cannot be considered adequately trained with respect to SA requirements. Material was provided to the Monitoring Team in response to a document request asking for curricula for restraint monitor training separate from formal CTD/DADS classes. The Monitoring Team was provided with a test entitled Restraint Monitor Training consisting of 13 questions. The Monitoring Team was not provided with any associated curriculum or topical outline related to restraint monitor training. Because there was not any formal curriculum provided by the Facility for this training the Monitoring Team is unable to validate whether or not the training is competency based. As a result, it is not possible for the Monitoring Team to determine whether the staff designated as restraint monitors can be considered adequately trained with respect to SA requirements. As noted below, there were numerous issues found with adequacy of monitoring, which puts into question whether the training provided the skills needed by monitors. Based on a review of 14 physical and chemical crisis intervention restraint records (Sample C.1.a and C.1.c), most staff recorded as the restraint monitor on the Restraint Checklist were not on the list of staff approved as restraint monitors provided by the Facility. Five of the 14 (36%) Restraint Checklists in the sample included an approved restraint monitor (irrespective of whether or not that person was properly trained); 64% of the restraints reviewed in the sample did not have a restraint monitor authorized by	

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		the facility to perform those duties. One of the primary duties of a restraint monitor is to conduct a face-to-face assessment and conduct a restraint debriefing that includes the provision of additional competency-based training to staff at the time of the debriefing. This would presumably include measures to ensure restraint documentation is completed and is clear and accurate. Based on a review of 14 physical and chemical crisis intervention restraint records (Sample C.1.a and C.1.c) none of the restraint documentation included a FFAD using the State approved form. Eight (57%) included the RSSLC form dated 4/06 titled "Emergency/Contingent Restraint Debriefing." This form does not contain all data requirements of the State required form. For example, in the case of chemical restraint, the RSSLC form does not require the review by a pharmacist and psychiatrist required in the State approved form. Even if the RSSLC form was equivalent, it is imperative that the Facility use forms, and follow procedures, that are required by State policy. The lack of adherence to State office policy requirements was a significant finding in the last compliance review. The Monitoring Team is very concerned that six months later the changes necessary to comply with the State requirements were still not in place. The State required policy (and related forms to document) were developed to ensure that, if followed, the terms of the SA would be met. RSSLC cannot achieve compliance with this section of the SA unless it fully implements State policy and the related methods and forms for documentation. RSSLC recently revised its restraint policy to conform to State policy. The Monitoring Team will expect to observe diligent implementation of this revised policy in its next review. A properly trained restraint monitor would have detected obvious issues on Restraint Checklist and noted how the issue was addressed (such as a corrected entry on the Restraint Checklist) and/or retraining of staff. Any documentation of retraining of staff would be expected to be included in the restraint files prepared for the Monitoring Team. Examples of obvious issues that should have been addressed include: • By policy the level of supervision required when a person is in restraint is 1:1. In nine of 14 (64%) the level of supervision noted on the Restraint Checklist is "routine." This was the case for Individuals #455(3x), #448 (3x), #630, #267, and #25. • The Restraint Checklist for Individual #448 (8:50am) had the individual's name inverted--the last name in the first name box and vice-versa. While this may not seem all that important it is illustrative of the lack of attention being given to restraint monitoring. • The Restraint Checklist for Individual #267 indicated the method of restraint was horizontal side-lying. It also indicated only one staff was involved in the	

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		restraint. The person was in restraint five minutes. Horizontal side-lying restraint requires two staff to ensure the safety of the individual. There was no debriefing provided associated with this restraint so the Monitoring Team cannot determine what the actual circumstances associated with this restraint were and what might have occurred as follow-up, such as retraining of staff. The Director of the Psychology Department acknowledged that there were issues with restraint monitors and as a result the Facility had recently decided to designate unit behavior analysts and psychology assistants as primary restraint monitors. In the future, only if these individuals were unavailable would other staff serve as restraint monitors and this would be limited to trained Unit RNs, Campus Coordinators and Campus Administrators. None of the 14 crisis intervention physical and chemical restraint records in the sample indicated an alternative physician-ordered monitoring schedule. There was not a practice of physician specification of type and schedule of monitoring required for medical restraints even though this is required by the SA. Based on a review of 10 restraint records for restraints that occurred at the Facility (Sample #C.1 for Individuals: #455, #448, #630, #25, #58, and #267), there was documentation that a licensed health care professional: ▪ Did not monitor the Individual listed below least every 30 minutes from the initiation of the restraint in six of the ten (60%) instances of restraint. Listed below are Individuals and dates of each restraint record where this did not occur: o Individual #448 – 1/7/11 at 8:52 a.m. o Individual #448 – 1/7/11 9:02 a.m. ▪ A physical hand hold restraint was applied twice within 10 minutes time because Individual #448 first pulled the fire alarm station in the hallway and kept pulling the handle to tear it off. Then Individual #448 went into the Behavior Analyst's office and started throwing property around the office. The physician was not notified of the restraint incidents until 11:00 a.m. on 1/7/11. Subsequently, at 11:00 a.m., the nurse monitored Individual #448's vital signs. Although the physical hand hold restraints were applied for five minutes or less each time, there was a two hour delay in notifying the physician and the nurse of the restraint incident. The Facility failed to follow the Restraint Policy. o Individual #448 – 1/7/11 at 9:20 a.m.	

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		▪ A physical hand hold restraint was applied again because Individual #448 was still showing aggressive behavior after the previous restraint incident mention above. Individual #448 threw a heater across the room and a bicycle pump at the Behavior Analyst. The physician was not notified of the restraint incidents until 11:00 a.m. on 1/7/11. Subsequently, at 11:00 a.m., the nurse monitored Individual #448's vital signs. Although the physical hand hold restraint were applied for five minutes there was approximately an hour and 35 minutes delay in notifying the physician and the nurse of the restraint incident. The Facility failed to follow the Restraint Policy. o Individual #630 – 3/28/11: A physical horizontal (side-lying) restraint was applied at 4:22 p.m. to Individual #630. The individual wanted to go shopping when it was not on his schedule. He left the home and campus and walked into the middle of the public street and became verbally and physically aggressive toward staff and was throwing rocks. Staff attempted to verbally redirect and block before physical restraint was used in order to remove him from the street. This crisis intervention restraint was not specified in a Safety Plan. The physician was not notified of the restraint until 4:45 p.m. on 3/28/11. Subsequently, the nurse monitored vital signs but the time vital signs were monitored was not documented on the Restraint Checklist. The Facility failed to follow the Restraint Policy. ▪ Monitored and documented vital signs in 10 of the 10 (100%) restraint incidents. While vital signs were monitored and documented for all 10 restraint incidents, the Restraint Policy was not followed for Individuals #448 and #630, as discussed above. ▪ Monitored and documented mental status in 10 of the10 (100%) restraint incidents. While mental status was monitored and documented for all 10 restraint incidents, the Restraint Policy was not followed for Individuals #448 and #630, as discussed above. Based on documentation provided by the Facility, one restraint had occurred off the grounds of the Facility in the last six months. A sample of one was reviewed (Sample #C.5). A licensed health care professional: ▪ Did not monitor the individual listed below within 30 minutes upon on return to the campus: o Individual #630 – 3/28/11 at 4:22 p.m.: • A physical horizontal (side-lying) restraint was applied at 4:22 p.m. to Individual #630. The individual wanted to go shopping when it was not on his schedule. He left the home and campus	

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		and walked into the middle of the public street and became verbally and physically aggressive toward staff and was throwing rocks. Staff attempted to verbally redirect and block before physical restraint was used in order to remove him from the street. The physician was not notified of the restraint until 4:45 p.m. on 3/28/11. Subsequently, the nurse monitored vital signs but the time vital signs were monitored was not documented on the Restraint Checklist. The Facility failed to follow the Restraint Policy. • Monitored and documented vital signs in one (100%). For Individual #630 – 3/28/11 at 4:22 p.m.: While vital signs were monitored and documented for the restraint incident, the Restraint Policy was not followed for Individual #630, as discussed above. • Monitored and documented mental status in one (100%). For Individual #630 – 3/28/11 at 4:22 p.m.: While mental status was monitored and documented for the restraint incident, the Restraint Policy was not followed for Individual #630, as discussed above. Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 20% of the individuals for whom medical restraint was used. It included the following individuals: Individual #551, #296, #199, #598, #555, #353, #254, #369, and #399. For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. ▪ In no case (100%) did the physician specify the schedule of monitoring required; and ▪ In no case (100%) did the physician specify the type of monitoring required.	
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	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. A sample (Sample C.1.1 and C.1.3) of 14 Restraint Checklists for individuals in non-medical physical and chemical restraint was selected for review. The following compliance rates were identified for each of the required elements: 1. In five (36%), continuous one-to-one supervision was documented. 2. In 14 (100%), the date and time restraint was begun was documented. 3. In 14 (100%), the location of the restraint was documented. 4. In nine (64%), information about what happened before, including the change in	Noncompliance

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	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 behavior that led to the use of restraint, was documented. The other five did not include sufficient information describing the change in behavior that led to the use of restraint. 5. In 11 (79%), the interventions taken by staff prior to the use of restraint were documented and were adequate for post restraint review. The Restraint Checklist for Individuals #448 (8:52am), #267, and #630 did not indicate that interventions in the PBSP and interventions in the Safety Plan were used even though these individuals had a PBSP and a Safety Plan. 6. In 14 (100%), the specific reasons for the use of the restraint were documented. 7. In 14 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint were indicated on the restraint checklist. 8. In 14 (100%), the names of staff involved in the restraint episode were indicated on the restraint checklist. Seven (50%) of the restraints in the sample included use of the horizontal side-lying technique. For six of these seven restraint episodes at least two staff listed as applying the restraint. 9. The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in physical restraint, including: o In all 10 (100%) physical restraints the observations were documented frequently and at release. The longest restraint was eight minutes. o In all 10 (100%), the specific behaviors of the individual that required continuing restraint were noted. o Because of the short duration of all 10 physical restraint episodes reviewed there was no obvious need for staff to provide, during the restraint, opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. o In 10 (100%), the level of supervision provided during the restraint episode was recorded on the restraint checklist. o In 10 (100%), the date and time the individual was released from restraint was recorded on the restraint checklist. 10. The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in chemical restraint, including: o In 3 (75%) chemical restraints, the observations documented occurred as specified in policy. The one that did not was for Individual #58. o In 3 (75%), the specific behaviors of the individual that required restraint were noted. No information was provided on the Restraint Checklist for Individual #798. o In 1 (25%), the Restraint Checklist noted during the restraint, opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. This was the case with Individual #798. o In 1(25%), the level of supervision provided during the restraint episode	

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		was recorded on the restraint checklist. This was the case with Individual #361. 11. In 11 of 14(79%), the results of assessment by a licensed health care professional were documented as to whether there were any restraint-related injuries or other negative health effects. This was not the case with Individuals #455 (2x), and #58. In a sample of 14 records (Sample C.1.a and C.1.c), FFADs had been completed for 0(0). Eight contained an alternative form, "Emergency/Contingent Restraint Debriefing". These forms did not require as much data to be collected as the State required form. Additionally, they contained little substantive narrative information that would facilitate a thorough review of the circumstances associated with the restraint episode. Five of the eight were completed by a person the Facility had not designated as an authorized Restraint Monitor. A sample of nine of individuals who received medical restraint was reviewed (Sample #C.3). These restraints were selected from a larger set of medical restraint documentation provided to the Monitoring Team. This sample included 11 instances of pre-treatment sedation for these nine individuals. The documentation provided to the Monitoring Team with respect to the 11 instances of pre-treatment sedation was insufficient to validate that monitoring of individuals subject to pretreatment sedation (medical restraint) occurred in any organized manner. RSSLC Policy J.11 governed the use of sedation and does not include provisions for monitoring as required by State policy. The Facility should review language used in relevant policies at other SSLCs. An example of language from a policy from another SSLC that might be used is as follows: "If a health care provider or dentist orders a use of restraint for medical/dental treatment the written order must include: 1. Type of restraint 2. Clinical justification for the use of the restraint 3. Duration of the order 4. The schedule and type of monitoring required 5. Special instructions for the individual's care, if any, while restraints are being used." This sample policy further states "while an individual is restrained, staff must monitor the individual as ordered to ensure that the individual is not in physical distress and has not sustained an injury from the restraint. The evaluations will be documented on the Restraint Checklist and in the integrated progress notes." The Monitoring Team asked for all documentation associated with the medical restraints	

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		in the sample, including restraint checklist, face-to-face assessments, medical orders, physician specified monitoring schedule, any standard facility protocol for monitoring medical restraint, any PSP information regarding development and/or implementation of plans to minimize use of medical restraint for the individual (including data sheets if a program was developed and implemented), documentation of review activity, and any other information that would be helpful in understanding the circumstances associated with this restraint use. The information provided by the Facility in response to this request was insufficient to enable a review by the Monitoring Team in 11 of 11 cases of pre-treatment sedation (100%). For example, policy requires that the Restraint Checklist and Face-to Face Assessment/Debriefing (FFAD) be used in all instances of restraint use. The policy (both State and RSSLC) does not exclude medical restraints from this requirement. In its review of medical/dental restraint documentation the Monitoring Team did not find a Restraint Checklist or FFAD in any of the 11 restraint episodes for which the Facility was asked to produce documentation. While much of the data that would be recorded on the Restraint Checklist may be recorded elsewhere in the active record it should also be recorded on the Restraint Checklist as the policy requires. This would facilitate effective clinical review of restraint use for a specific individual by the PST. All restraint documentation should be maintained in the restraint tab in the active record even if components of the documentation are also found elsewhere RSSLC Policy J.1: Use of Restraint, RSSLC Policy J.11: Using Sedation for Medical/Dental Appointments, and RSSLC Policy J.13 Implementing Dental Treatment Support Plan 2/4/08 are directed at compliance with the requirements of the SA. Documentation review and interviews by the Monitoring Team suggests that staff who should understand this policy, primarily medical and nursing staff, did not, or if they did they did not consistently use the procedures in these policies correctly. Additionally, these policies apparently have not been reviewed with sufficient scrutiny to ensure they include all practices required by the State Policy and the SA, for example, the absence of instructions on monitoring and documenting monitoring of medical restraint use.	
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:	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. According to Facility documentation, during the six-month period prior to the on-site review, a total of four individuals were placed in restraint more than three times in any rolling thirty-day period. Documentation for four individuals (100%) who had more than three restraints during a rolling thirty day period was reviewed to determine if the requirements of the Settlement Agreement were met. The findings throughout this provision relate to those four individuals. The following documents were reviewed: the annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support	Noncompliance

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		Plans (PBSPs), structural and functional assessments (SFAs), 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. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. For four of the individuals/instances reviewed (100%), individuals' PSTs met to discuss the restraints.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	For zero of the individuals/instances reviewed (0%), the individual's PST reviewed the individual's adaptive skills. Documents reviewed included no examples of an adequate review of adaptive functioning, as none of the individuals had a current assessment of adaptive skills. ▪ For Individual #174, no adaptive assessment had been completed since 7/25/2005. ▪ For Individual #429, no adaptive assessment had been completed since 3/22/1988. ▪ For Individual #455, no adaptive assessment had been completed since 5/20/2002. ▪ For Individual #630, no adaptive assessment had been completed since 10/30/2005. For zero of the individuals/instances reviewed (0%), the individual's PST reviewed the biological, medical and psychosocial factors. According to available records, no individuals had a comprehensive assessment of biological, medical and psychosocial factors.	Noncompliance
	(b) review possibly contributing environmental conditions;	For zero of the individuals/instances reviewed (0%), the individual's PST reviewed the possibly contributing environmental conditions. No individuals had assessments where the contingencies for the undesired behavior were specifically identified. The following are examples of where teams failed to do this adequately: ▪ For Individual #455, the role of mental illness as a setting event or motivating operation was not investigated. Mental illness can alter the interpretation of the environment, thereby changing the strength of various environmental stimuli.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	For zero of the individuals/instances reviewed (0%), the individual's PST reviewed and/or performed structural assessments of the behavior provoking restraints. The following are examples of individuals for whom this was done appropriately:	Noncompliance

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		▪ For no individuals was a functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis completed. As a result, no functions for the undesired behavior were specifically identified. The following are examples of where teams failed to do this adequately: ▪ For Individual #174, results of the assessment process suggested several functions for the undesired behavior. No attempted to resolve the multiple functions was reflected in the documentation.	
	(d) review or perform functional assessments of the behavior provoking restraints;	The Behavior Services department at RSSLC combines the functional assessment and structural assessment into a single process. Please refer to Provision C.7(c).	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	For four of the individuals reviewed (100%), the individual had a PBSP. Of the four individuals in the sample who had PBSPs, the following was found: ▪ Zero (0%) were based on the individual's strengths; ▪ Zero (0%) specified the objectively defined behavior to be treated that led to the use of the restraint; ▪ Zero (0%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint; and ▪ Zero (0%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. The following are examples of individuals who had inadequate PBSPs: ▪ For Individual #630, the following problems were noted in the PBSP. o The process for teaching the replacement behavior included these steps; because there was not adequate functional assessment to identify the function of the target behavior, this replacement behavior was not established to provide an alternate means to accomplish the function maintaining the target behavior: 1) Staff will assist the individual to identify things that he wants or needs, 2) If he does ask for something appropriately, praise him for doing so, 3) If he does not, teach the individual how to ask for something in a more appropriate way such as "May I talk to you"?, or "May I play this game with you"?, and 4) After he does praise him for doing so. This methodology lacked the details and specificity necessary for consistent implementation. Furthermore, the intervention lacked guides for prompting, instructions for documentation, and the potential for high rates of reinforcement. o The instructions for addressing displays of self-injury included as the first step, "In the event of self-injury, quietly and respectfully ask him to stop." There was no indication in the behavior assessment that requesting that he stop is an effective approach to stopping the self-	Noncompliance

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		injury. As a result, this approach could increase the potential for injury to the individual. o The goals and objectives for the program included the following expectations. The time parameters included in the expectations were not based upon expectations for the behavior derived from careful assessment, but rather by the individual's next annual PSP. The arbitrary use of annual PSP dates for treatment expectations increases the probability that an ineffective PBSP will be continued for too long, thereby denying meaningful services and potentially increasing the risk to the individual. This is especially of concern when an individual is experiencing high use of restraint to protect self or others. ▪ The individual will exhibit 10 or less incidents of aggression to others by 6/1/11. ▪ The individual will exhibit 18 or less incidents of aggression to self by 6/1/11. ▪ The individual will exhibit 2 or less incidents of leaving without informing staff by 6/1/11. ▪ The individual will exhibit replacement behaviors on 80% of possible occasions by 6/1/11. The Safety Plans of the individuals in the sample were reviewed. The following represents the results: ▪ In four out of four of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; ▪ In four (100%), the maximum duration of restraint authorized was specified; ▪ In four (100%), the designated approved restraint situation was specified; and ▪ In four (100%), the criteria for terminating the use of the restraint were specified.	
	(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	At the time of the current site visit, the Facility had just implemented a process for reviewing data quality and establishing inter-observer agreement. Due to the recent initiation of this process, it was not possible to assess the benefits of the process. For zero of the individuals reviewed (0%), were integrity checks conducted to determine whether the treatment was provided consistently and as written..	Noncompliance
	(g) as necessary, assess and revise the PBSP.	In one of the records reviewed (25%), there was documentation that the individual's PBSP had been revised as appropriate. The following is an example of an individual for whom this was done appropriately:	Noncompliance

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		▪ For Individual #429, documentation reflected that, following four months of elevations in self-injury, the functional assessment was reviewed and the PBSP revised. The following are examples of where the PST failed to do this adequately: ▪ For Individual #174, data on self-injury had not indicated a consistent response to treatment over the previous 12 months. A safety plan was implemented in September of 2010, but documentation did not reflect any changes to the PBSP. ▪ For Individual #455, aggression had been increasing since September 2010 without a revision to the PBSP. ▪ For Individual #630, aggression had been greater than baseline for only one out of 12 months. The record did not reflect any attempt to fade or otherwise revise the PBSP.	
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.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. State policy (and as of 3/1/11 RSSLC policy) for the review of crisis intervention restraints is: 1. Within 24 hours of the individual's release from restraint that is not authorized by a Safety Plan, the QMRP or AOD will notify the individual's LAR, or the person listed in the individual's record as primary correspondent, that the individual was restrained, with information about the type of restraint and the individual's condition. The AOD will notify the QMRP that the contact was made. The QMRP will document the contact in the contact log in the individual's record. 2. Restraint reviews are conducted to determine if each application of restraint was justified, if each restraint was applied correctly, and to determine if factors exist that if modified might prevent the future use of restraint. a. The PST will meet and review each use of restraint as a crisis intervention that is not authorized by a Safety Plan within one working day of the restraint. b. Within three business days of the start of each episode of restraint, other than medical/dental restraint, the circumstances under which the restraint was used will be reviewed, based on the Restraint Checklist, the Restraint Debriefing Report, and as applicable the Administration of Chemical Restraint Consult form, at the Unit Meeting and at the Incident Management Meeting. 3. Review of chemical restraint in part includes assessment of the apparent effectiveness of the chemical restraint in reducing the dangerous behavior in the	Noncompliance

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		hours after administration. 4. Restraint Checklists will be reviewed at Unit Meetings to ensure completeness, with the Unit Director or designee assigning responsibility for corrections needed. The RSSLC process for reviewing each episode of restraint, as reported by staff and through observation, began with each instance of restraint being reported and reviewed in the unit morning meeting the next business day with whatever information has been prepared by the time of the meeting. This often consisted of verbal reports from staff and appeared to consist almost entirely of making sure key information had been recorded on the Restraint Checklist. The Unit Morning Meeting observed by the Monitoring Team consisted of a very brief review to ensure certain data had been recorded of a restraint that occurred the prior day. There was no discussion of the circumstances of the restraint or any discussion to determine if factors exist that if modified might prevent the future use of restraint. An administrative staff person from the Psychology Department also observed the meeting and asked if this was the typical way restraints were reviewed. The Unit Director answered it was. If the RSSLC considers the review done at the Unit Meetings to represent the restraint review called for in the SA and by policy, substantial improvement in the scope and depth of review will need to occur. The observation of the Monitoring Team suggests that at best the existing Unit Review was directed at policy requirement number 4 from the policy language noted above. There is evidence in the restraint files prepared for the Monitoring Team that, for the most part, PST reviews occurred within one day (the language in 2.a). There is nothing to indicate that the language in 2.b is addressed in any substantive or meaningful way at RSSLC. This is a serious barrier to achieving compliance with the SA. Facility staff refers to the IMRT as a restraint review body but through interview and observation that review was perfunctory with members not having documents and data to review. Any review that occurred at IMRT was based primarily on anecdotal information and the account of events presented by the Unit Director or Unit psychologist. When questioned about this process administrative staff indicated that the substantive review of restraint use occurs at the Unit Meeting but as noted above this is not the case. There was no substantive combined clinical and administrative review of restraint episodes at the RSSLC nor was there a process in place to achieve this. Additionally for a restraint review process to be effective it is important that documents used to record use of restraint be complete and contain sufficient information to facilitate an appropriate clinically oriented review at the Unit Morning Meeting, the Incident Management Review Team (IMRT), and the individual's PST. It may be desirable to expand upon the data required in State approved policy and documents, particularly the FFAD, to include more complete data from which the IMRT and the individual's Personal	

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		Support Team may better understand circumstances and develop strategies to address issues impacting restraint use. For example, the Monitoring Team has observed a process at another SSLC where a psychologist reviews each restraint episode and writes a debriefing (supplementing the FFAD) which addresses the following questions: 1. Describe the resident at the time the restraint was used? What was the resident doing that required restraint? What types of emotions were being shown by the resident? 2. Describe what led up to the restraint. "What was going on in the environment prior to when the resident displaying challenging behavior? What might have caused the resident to act the way he or she did?" 3. When the resident first started showing that he or she was upset, and started displaying the precursors of the challenging behaviors that led to restraint, how did staff try to calm the resident? What interventions were tried prior to restraint, and how did the resident respond? 4. How can we prevent the need for restraining this resident in the future? If a similar situation develops, is there anything we can do instead of restraining the resident? Is there anything we can change in the environment where the restraint occurred that might make it less likely that the resident will again need to be restrained there? 5. Were injuries noted secondary to the restraint? In this process being provided as an example, the psychologist prepares the debriefing document after interviewing all staff involved in the restraint and working with the individual prior to the restraint episode. For the most part the content of the debriefing document is sufficiently detailed to be useful to the psychology staff and the PST in determining future actions that may prevent the need for restraint. The minutes of the Restraint Reduction Committee report discussion of restraint data, planned policy changes, and restraint tracking. This suggests that the role of this committee is primarily to review administrative related issues. The minutes did not include a list of attendees. Restraint Reduction Committees at other SSLCs also review administrative related issues but have expanded the role to include focused clinical discussion. This typically occurs through case study presentations at the meeting, usually of a complicated case. Discussion of this type can also reinforce the need for, and benefit of, interdisciplinary discussion and problem solving.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:
1. Supplemental restraint policies (all of the J series except J.1) need to be reviewed and revised as needed to ensure they comport to policy J.1, including consistent use of definitions and terms.
2. RSSLC restraint policies need to be uniformly implemented.

3. The Facility should review language used in policies addressing pre-treatment sedation and chemical restraint at other SSLCs.
4. The Trend Analysis Report needs to track more data elements over time, at least for the equivalent time period the summary data is tracked.
5. Additional training should be provided to ensure implementation of side-lying restraint techniques do not inadvertently include the individual being in a prone position during any phase of the restraint implementation.
6. Significant deficient practices are presented in Section K that impact the use of restraint at the RSSLC. These issues need to be effectively addressed in order to reduce the use of restraint at the RSSLC, especially the use of chemical restraint. Behavior support plans should include concrete strategies for deescalating behavioral incidents specific to each individual. Revise behavior support plans if they are not effective tools for direct support staff responsible for plan implementation.
7. The process for review of individual restraint episodes at both the unit and IMRT level needs substantial improvement including a more clinical orientation. The scope of restraint reviews must be more comprehensive than merely validation that forms are completed properly and should be conducted to determine if each application of restraint was justified, if each restraint was applied correctly, and to determine if factors exist that if modified might prevent the future use of restraint. These reviews, the corresponding recommendations, and any follow-up should be well documented.
8. Direct Care Professionals interviewed by the Monitoring Team demonstrated insufficient knowledge in restraint policy and application and additional training is needed. Training should be provided to direct support professionals to ensure that they are prompting the use of replacement behaviors and other coping strategies and documenting their use, when appropriate, on restraint checklists. In order to ensure that staff has adequate knowledge and skills related to restraint, supervisors should quiz staff often on the restraint policy, and on proper use of restraints.
9. The Restraint Reduction Committee should expand its scope and begin reviewing specific cases with an emphasis on discovering the underlying causes for individuals with the most frequent use of restraint.
10. Immediate attention should be given to those individuals for whom restraint, particularly chemical restraint, is employed frequently. This should include a review of the individuals' Behavior Support Plans, with revisions made accordingly. Ongoing review of data is essential, and should occur as part of the systems developed to reduce the overall use of restraint. A member of each of the relevant clinical disciplines should participate in reviews of frequent use of restraints to assure active discussion of efforts to minimize the use of restraints.
11. RSSLC needs to purge all outdated forms and take steps to ensure only currently approved forms are in use at the Facility.
12. Implementation of medical and dental support plans put in place to decrease the use of medical restraint (pre-treatment sedation) should be regularly documented and summarized. Information should be summarized in PSP Monthly Reviews, along with behavioral and skill acquisition data, to ensure comprehensive interdisciplinary review. In addition, efforts should be made to ensure that all documentation accurately and consistently reflects implementation steps.
13. The quality of documentation on the Restraint Checklist and the use of the Face-to-Face Assessment/Debriefing document should be improved, ensuring both documents are completed correctly with accurate data.
14. Medical staff need additional training on restraint related policy and procedure, specifically with respect to establishing restraint monitoring protocols specific to each restraint for chemical crisis intervention restraint and medical restraint.
15. Nursing staff need additional training on restraint related policy and procedure, specifically with respect to monitoring requirements for chemical crisis intervention restraints and medical restraints and requirements associated with post restraint and post-release assessment.

The following are offered as additional suggestions to the Facility:

1. Implement a formal written system of psychology staff review and debriefing of each crisis intervention restraint.
2. Continue the auditing/monitoring activity that is beginning to produce compliance reports and use these data to initiate process improvements.
3. Initiate a practice of immediate retraining of staff as auditors/monitors discover issues.
4. Use compliance data to isolate problem areas, e.g. by home/shift and use this analysis to target resource application.

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. RSSLC Plan of Improvement (POI) 4/18/11 2. DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 6/18/10 3. DADS Policy 02.2 Incident Management 6/18/10 4. RSSLC Policy A.17 Managing Unusual Incidents 6/30/10 5. RSSLC Policy A.25 Securing Evidence 7/17/09 6. RSSLC Policy B.15 Taking Disciplinary Action Following Confirmed Abuse, Neglect, or Exploitation 8/1/07 7. RSSLC Policy B.26 Placing an Employee on Investigative Leave 6/30/10 8. RSSLC Policy C.0 Video Surveillance 1/3/11 9. RSSLC Policy C.1 Reporting Abuse, Neglect, Exploitation 2/24/11 10. RSSLC Policy C.2 Actions Following Report of Abuse, Neglect, Exploitation 2/18/11 11. RSSLC Policy C.3 Actions Following Investigation of Abuse, Neglect, Exploitation 2/22/11 12. RSSLC Policy D.8 Completing/Routing Client Injury Report 3/10/11 13. RSSLC Policy E.10 Participating in Unit Morning Meeting 3/10/11 14. RSSLC Policy E.17 Completing Incident Information Reports 2/28/11 15. RSSLC Policy F.1 Scheduling Annual Personal Support Plan Meetings 3/24/11 16. Log of Serious Incidents 10/25/10 to 4/22/11 17. Log of Serious Injuries 10/25/10 to 4/19/11 18. CMS 2567 for survey completed 11/8/10, 1/28/11, and 3/10/11 19. Incident Management Meeting minutes for 3/7/11, 3/14/11, 3/21/11, 3/28/11, 4/4/11, 4/11/11, 4/18/11, and 4/25/11 20. Individual Training Records and personnel documentation for RSSLC Investigators 21. Individual Training Records and personnel documentation for DFPS Investigators 22. Sample documentation of volunteer background checks 23. Sample documentation of employee background checks 24. RSSLC Criminal Background Checks report 9/3/10 25. Training curriculum for Abuse, Neglect, and Exploitation 26. Acknowledgement of Reporting signed forms for 20 randomly selected employees 27. Abuse and Neglect Allegations log 10/25/10 – 4/19/11 28. DFPS Investigation Reports and related documentation for cases 38413301, 38809036, 38592634, 38479098, 38521482, 38203741, 38798375, 38843655, 38745482, 38855851, 38592634, and 38896039 29. DADS Report LSHR115 Employee Action Report with Termination Reason 1/1/11 to 5/2/11 30. Personnel action documentation for sample of employees 31. Number of Injuries by Severity log 11/1/10 to 5/4/11

	32. Log of allegations reported by Individuals, Legally Authorized Representatives (LARs), or family members 33. Document prepared by RSSLC with regard to the audit process to detect under reporting of injuries 34. Materials used to educate Individuals, LARs, and family members on Abuse, Neglect, and Exploitation 35. Incident Information Report (E.17) for Individuals #25, #641, #529, #592, and #315 36. Log of injuries where an Individual caused injuries to other individuals 11/1/10 to 5/2/11 37. Unusual Incident Reports (UIRs) 026, 031, 042, 055, 062, 063, 077,079, 090, 091, 094, 095, 127, 129, 131, 137, 141, 146, and 150. 38. Administrative Review Team for Client Injury Reports (CIRs) and E.17s minutes for 3/30/11, 3/31/11, 4/1/11, 4/4/11, 4/5/11, 4/6/11, and 4/7/11 39. Staff Training Records (25 randomly selected employees) 40. Self-Advocate meeting minutes 12/8/10, 2/16/11, 3/23/11, and 4/11/11 **People interviewed:** 1. Jane Purcell, Assistant Director of Programs 2. Joan Poenitzsch, Director of Quality Assurance 3. Judy Miller, Settlement Agreement Coordinator 4. Reuben Muhammad, Incident Management Coordinator 5. Omar Akmal, OIG Investigator 6. Jim North, Human Rights Officer (HRO) 7. Ten Direct Care Professionals (DCPs) **Meetings attended/Observations:** 9. Incident Management Team Meeting (IMRT) 5/2/11 10. Human Rights Committee (HRC) meeting 5/5/11 11. Four Rivers Unit Morning Meeting 5/5/11 12. Quality Assurance/Quality Improvement (QA/QI) Council 5/3/11 13. Administrative Review Team 5/3/11 14. Meeting with QA Department Staff 5/4/11
	Facility Self-Assessment: The RSSLC POI reported substantial compliance with two of the five provisions in Section D of the Settlement Agreement (SA). The Monitoring Team was able to substantiate compliance with one of these four provisions. The Monitoring Team concurred with RSSLC that it is in substantial compliance with Provision D.5. Provision D.5 addresses required background checks of employees and volunteers. For Section D.1 RSSLC reported it was in substantial compliance. The Monitoring Team did not concur. In the first compliance review the Monitoring Team had rated this provision as being in substantial compliance. Because significant implementation issues were identified during this review the Monitoring Team could not validate substantial compliance in this review. For Section D.2 RSSLC reported it was in substantial compliance with three of nine components. The Monitoring Team determined RSSLC was in substantial compliance with two of nine components. These were D.2.b which requires that the Facility has mechanisms to ensure that, when serious incidents such as

	allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well-supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation and D.2.h, which requires a mechanism to ensure reporters of abuse and neglect are not subject to retaliation. For Section D.3 RSSLC reported it was in substantial compliance with seven of the 10 components of the provision. The Monitoring Team determined that RSSLC was in substantial compliance with only five of the 10 components. These were D.3.b which requires the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation; D.3.c which requires that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations; D.3.d. which requires the safeguarding of evidence; D.3.e which requiresthat the written investigation report, together with any other relevant documentation, be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent; and, D.3.j that requires records of the results of every investigation be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual and that any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. For Section D.4 RSSLC reported it was not yet in compliance and the Monitoring Team agreed with this self-assessment.
	Summary of Monitor's Assessment: RSSLC policies relevant to incident management are difficult to follow; several could be combined for ease of understanding and administration. All or parts of RSSLC policies A.17 Managing Unusual Incidents, A.25 Securing Evidence, B.15 Taking Disciplinary Action Following Confirmed Abuse, Neglect, or Exploitation, B.26 Placing an Employee on Investigative Leave, C.0 Video Surveillance, C.1 Reporting Abuse, Neglect, Exploitation, C.2 Actions Following Report of Abuse, Neglect, Exploitation, C.3 Actions Following Investigation of Abuse, Neglect, Exploitation, D.8 Completing/Routing Client Injury Report, E.10 Participating in Unit Morning Meeting, and E.17 Completing Incident Information Reports are intended to address this section of the SA. The Monitoring Team found these policies to be a set of poorly organized statements that individually, and collectively, did not fit together in a logical presentation of either Facility policies or procedural practices. This has two consequences.First, many things required to achieve compliance with the SA were not in policy or were not stated clearly; second, staff trying to comply with policy may often become confused as they attempt to understand how certain policies apply to their daily work. The policies should be structured in a more organized manner using a standard methodology for compartmentalizing information using an outline format. The RSSLC policies referenced in this section seldom had clear policy related statements. Policies at other SSLC's usually are organized in a manner where there is a topical heading that addresses the subject matter of each requirement of the settlement agreement, under which the Facility articulates its policy and practices relevant to that requirement of the SA. This format seems to allow a Facility to ensure work efforts and resources that they expect will lead to

	substantial compliance are directed at identified SA requirements. Investigations were completed using a standard format, and, for the most part, were conducted in a timely fashion. Some documentation issues still needed to be addressed, such as recording supervisory reviews and their content. Training for staff on abuse and incident reporting was in place, and all staff were current in that training. However, work continued to need to be done to ensure that staff were competent in understanding signs and symptoms of abuse, their responsibilities with regard to reporting, and the reporting procedures. An area that continued to need improvement was the inclusion of adequate recommendations based on the results of investigations, and follow-through on those recommendations. Facility investigators made recommendations, but they more often related to the immediate protection of the individual as opposed to systemic issues they encountered such as crowded environments, peers who did not get along, and a lack of meaningful activities. The data in the RSSLC Allegations of Abuse/Neglect/Exploitation Trend Report (3/31/11) were difficult to interpret. In the trend report for the period 10/1/10 to 3/31/11, unexplained discrepancies were noted. Section A (the line that reports total DFPS cases) reported no cases of category I physical abuse. Section A (the line that reports total allegations) reported one case of category I physical abuse. Section A (the line that reports total DFPS cases) reported 36 cases of category II physical abuse. Section A (the line that reports total allegations) reported 46 cases of category II physical abuse. These reports need to include a footnoted description of what the data represents to avoid inaccurate interpretations by anyone reviewing them. Without further information the Monitoring Team would conclude DFPS was not investigating the one Class I physical abuse allegation and 10 Class II physical abuse allegations. This is one way (and may not be the correct way) to interpret these data. There continues to be a problem with timely response from DFPS in initiating investigations. Initial investigatory activity exceeded the 24 hour requirement in every case reviewed by the Monitoring Team, sometimes by days. Based on an interview of 10 staff responsible for the provision of supports to individuals, 9 (90%) were able to correctly describe the complete reporting procedures for abuse. The Facility had hired additional investigators so that an investigator is onsite 24 hours a day seven days a week. The Facility had also implemented a video surveillance program since the last review. While the Monitoring Team believes that Facility policy demonstratescommitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect, and has practices in place to achieve this, issues were identified in this review that demonstrate concerns related to the effectiveness of these policies and practices.

	The self-advocacy group meetings, and observation of the meeting held the week of the review, did not reflect any presentation or discussion of abuse/neglect issues. Although such discussion would not be expected a part of the agenda of each meeting, individuals at the meeting did not provide accurate statements of what to do if someone harmed them. The Human Rights Officer, who facilitated the meeting, stated that there had been such discussions, and that individuals usually can tell what to do, but he agreed they did not do so at this meeting. Late reporting of incidents occurs too often. In two of six (33%) DFPS investigations the initial report of alleged abuse or neglect by the Facility to DFPS did not occur within one hour of discovery or suspicion of the incident leading to the report to DFPS. In three of five (60%) investigations of serious injuries and incidents the incidents were not reported immediately (within one hour) to the Facility Director/designee as required by policy. The Facility established an Administrative Review Team to review all Client Injury Reports (CIRs) and Incident Information Reports (E.17s). This group meets twice a week. From the meeting attended by the Monitoring Team it appears documents are provided to members of the team to review (each member gets a specific set of documents) and that member reports on any issues they identified with their assigned reports. This process is an additional process to the ordinary work processes that include document review and should result in improved performance. At the meeting attended by the Monitoring Team, documents were provided to members of the team to review (each member got a specific set of documents) and that member reported on any issues they identified with their assigned reports The Facility is commended for its initiative in this area. In every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no contact status. Limited effort was directed at informing individuals, guardians, and LARs of abuse reporting responsibilities and procedures. The Monitoring Team would like to commend the RSSLC for convening periodic joint meetings with DFPS and OIG at which any issues of mutual cooperation can be reviewed and resolved. With respect to tracking investigation follow-up activity, the Facility reported in the POI that "all information is tracked in the UIR follow-up section." This is insufficient to demonstrate compliance with the SA. In reviewing the follow-up actions for DFPS cases, actions were identified with a person responsible and a target date noted. There was not any notation on any of the UIRs that the intended follow-up occurred, and when, and whether or not it was effective.

#	Provision	Assessment of Status	Compliance

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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.	In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team does not concur. In the first compliance review the Monitoring Team had rated this provision as being in substantial compliance. Because significant implementation issues were identified during this review the Monitoring Team could not validate substantial compliance in this review. The Facility's policies and procedures included a commitment that abuse and neglect of individuals will not be tolerated and required that staff report abuse and/or neglect of individuals. According to the RSSLC Policy C.1: Reporting Abuse, Neglect, Exploitation, staff was required to report abuse, neglect, and exploitation to DFPS within one hour by calling the DFPS 1-800 number. This was consistent with the requirements of the Settlement Agreement (SA). Based on an interview of 10 staff responsible for the provision of supports to individuals, 9 (90%) were able to correctly describe the complete reporting procedures for abuse, neglect, and/or exploitation. One person did not mention calling the DFPS number and reported they would report abuse to their supervisor. The Facility had hired additional investigators so that an investigator is onsite 24 hours a day seven days a week. The Facility had also implemented a video surveillance program since the last review. These measures and ongoing staff training demonstrate the Facility's commitment to ensure that abuse and neglect of individuals are not tolerated, and to encourage staff to report abuse and/or neglect. The Monitoring Team believes that Facility policy demonstratescommitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect, and has practices in place to achieve this; therefore, this provision is found in substantial compliance. Nevertheless, issues were identified in this review that demonstrate concerns related to the effectiveness of these policies and practices. For example, as noted in the findings for Provision D2(a), examples of delay in reporting are inconsistent with a general understanding of the Facility's commitment to not tolerate abuse and neglect. Furthermore, as described in the findings for Provision D2(3), limited effort was directed at informing individuals, guardians, and LARs of abuse reporting responsibilities and procedures.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring	Noncompliance

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	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:	Team concurs. RSSLC policies A.17 Managing Unusual Incidents, A.25 Securing Evidence, B.15 Taking Disciplinary Action Following Confirmed Abuse, Neglect, or Exploitation, B.26 Placing an Employee on Investigative Leave, C.0 Video Surveillance, C.1 Reporting Abuse, Neglect, Exploitation, C.2 Actions Following Report of Abuse, Neglect, Exploitation, C.3 Actions Following Investigation of Abuse, Neglect, Exploitation, D.8 Completing/Routing Client Injury Report, E.10 Participating in Unit Morning Meeting, and E.17 Completing Incident Information Reports are intended to address this and other provisions of the SA. The Monitoring Team found these policies to be a set of poorly organized statements that individually, and collectively, did not fit together in a logical presentation of either Facility policies or procedural practices. This has two consequences.First, many things required to achieve compliance with the SA were not in policy or were not stated clearly; second, staff trying to comply with policy may often become confused as they attempt to understand how certain policies apply to their daily work.Examples are provided throughout Section D of this report. The policies were not presented in a traditional outline and indexed format. Most are devoid of policy statements and focus primarily, if not exclusively, on procedural steps associated with the policy title; for example, Policy C.2 is titled "Actions Following Report of Abuse, Neglect, Exploitation." The contents of this policy are usually found within a broader policy on Abuse, Neglect and Exploitation which would typically describe a Facility's policies governing abuse, neglect, and exploitation followed by descriptions of the procedural steps the facility has put in place to insure those policies are implemented in the day to day administrative activity at the facility. The above referenced RSSLC policies need to be reviewed and revised, consolidated as appropriate, and aligned with each specific requirement of the SA. Policies should clearly be identified as policies and procedures should clearly be identified as procedures.	
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. RSSLC policies A.17 Managing Unusual Incidents, C.1 Reporting Abuse, Neglect, Exploitation, D.8 Completing/Routing Client Injury Report, and E.17 Completing Incident Information Reports were intended to address this provision of the SA. These four policies include the reporting requirements necessary to comply with this component of the SA. The Facility used a standardized reporting system.	Noncompliance

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	warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The information in these policies is not organized in a manner that presents a logical flow of information that staff would need to understand their reporting responsibilities. This could contribute to issues of late reporting of incidents.For example, in two of six (33%) DFPS investigations the initial report of alleged abuse or neglect by the Facility to DFPS did not occur within one hour of discovery or suspicion of the incident leading to the report to DFPS. This was the case for DFPS investigations 38745482 and38855851. In three of five (60%) investigations of serious injuries and incidents the incidents were not reported immediately (within one hour) to the Facility Director/designee. Those that were not reported within one hour included UIRs 094, 127, and 150. To assess whether the facility policies address this component of the SA, the Monitoring Team reviewed the list of all RSSLC policies provided in a document request. The only policy which by its title addressed reporting was C.1 Reporting Abuse, Neglect. It included specific instructions to staff with regard to reporting, and related responsibilities, if they suspect or have knowledge of abuse, neglect, or exploitation. This policy did not address other reportable incidents required by the SA (or State policy) such as death or serious injury. Reporting requirements for unusual incidents other than abuse, neglect, and exploitation were found in policy A.17 Managing Unusual Incidents. A staff person who would refer to a policy manual as reference material for understanding their reporting requirements would likely have difficultly because requirements are located in multiple policies and policy titles do not reflect important content. For example simply renaming policy A.17 to "Reporting and Managing Unusual Incidents" would increase the likelihood that staff could use it for reference material even though this policy does not (but should) provide definitions of abuse, neglect, and exploitation. The definitions of abuse, neglect, and exploitation are located in policy C.1. Policy A.17 merely lists "abuse, neglect, and exploitation:" as reportable events even though every other type of incident in the policy includes definitional terms. For example, a choking incident is included in the list of unusual incidents that must be reported. A choking incident is defined in the policy as: "any incident that requires the use of the Heimlich maneuver or immediate transfer to an acute hospital emergency room." The absence of definitions for the terms "abuse", "neglect", and "exploitation" in policy A.17 is of concern to the Monitoring Team. The Monitoring Team intended to provide statistical summaries with respect to abuse, neglect, and exploitation allegations, investigations, and disposition of investigations in this section of the report. Ordinarily these data are presented in Trend Reports prepared by each SSLC. The Monitoring Team reviewed the data in the RSSLC Allegations of Abuse/Neglect/Exploitation Trend Report (3/31/11). These data were difficult to interpret. In reviewing the trend report for the period 10/1/10 to 3/31/11, the Monitoring Team noted unexplained discrepancies. For example, Section A (the line that reports total DFPS cases) reported no cases of category I physical abuse. Section A (the	

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		line that reports total allegations) reported one case of category I physical abuse. Section A (the line that reports total DFPS cases) reported 36 cases of category II physical abuse. Section A (the line that reports total allegations) reported 46 cases of category II physical abuse. These reports need to include a footnoted description of what the data represents to avoid inaccurate interpretations by anyone reviewing them. Without further information the Monitoring Team would conclude DFPS was not investigating the one Class I physical abuse allegation and 10 Class II physical abuse allegations. This is one way (and may not be the correct way) to interpret these data. The issue of properly interpreting data on trend reports is further compounded when these data are compared to data prepared for the Monitoring Team during the review and displayed below. For example, the Trend Report indicated the Facility had 42 DFPS cases during the six-month period from October 1, 2010 through March 31, 2011 but 56 allegations of abuse. This variance needs to be explained as noted above. None of the data in the Trend Report, whatever the proper interpretation of it is, even closely comported to the report prepared by the Facility for the Monitoring Team during the review. From a response to a document request asking for the six month period from October 1, 2010 through March 31, 2011 - total number of abuse allegations and disposition/status the following data were provided by the Facility: Total Number of Abuse Allegations 71 Substantiated 13 Unfounded 1 Inconclusive 11 Administrative Referral 13 Disposition Pending 6 Unsubstantiated 27 Total Number of Neglect Allegations 26 Substantiated 8 Unfounded 1 Inconclusive 1 Administrative Referral 9 Disposition Pending 0 Unsubstantiated 7 Total # of Exploitation Allegations 1	

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		Substantiated 0 Unfounded 0 Inconclusive 0 Administrative Referral 1 Disposition Pending 0 Unsubstantiated 0 The number of unusual incidents as defined in RSSLC A.17 totaled 37. The following numbers were taken from the list of Serious Injuries 10/15/10-4/19/11 and Serious Incidents 10/25/10-4/22/11. • Deaths – 7 • Serious Choking Incidents/PICA – 5 • Life threatening illness or injury – 0 • Life threatening medication error – 0 • Serious Injury/Falls -11 • Sexual Incidents – 1 • Suicide Threats – 6 • Theft by Staff – 0 • Unauthorized Departures/law enforcement involvement – 7 Based on an interview of 10 staff responsible for the provision of supports to individuals, 9 (90%) were able to correctly describe the complete reporting procedures for abuse, neglect, and/or exploitation. One person did not mention calling the DFPS number and reported they would report abuse to their supervisor. Based on an interview of 10 staff responsible for the provision of supports to individuals, 7 (70%) were able to describe the reporting procedures for other serious incidents. Policy A.17 requires unusual incidents other than abuse, neglect, and exploitation to be reported to the Unit Director or designee. Three staff was unaware of this requirement and reported they would report the incident to their supervisor. RSSLC provided two reports:Serious Injuries (10/15/10 to 4/19/11) and Serious Incidents (10/25/10 to 4/22/11). From these reports the Monitoring Team was able to determine thatRSSLC had 10 serious injuries and 20 serious incidents (other than death) during these respective time periods. From these 30,five were selected for sample D.2 to assess the adequacy of the facility investigation process; although no specific criteria for selection were used, the Monitoring Team attempted to ensure that both substantiated and unsubstantiated findings were represented, and selection was, to the degree possible, from among the most recent investigations.	

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		Two samples of investigations were selected for review. These included: • Sample D.1 included a sample of six DFPS investigations of abuse, neglect, and/or exploitation between 10/25/10 and 4/15/11. This sample included the following DFPS investigation reports 38798375, 38843655, 38745482, 38855851, 38592634, and 38896039. • Sample D.2 included a sample of five Facility investigations between 10/25/10 and 4/15/11. Sample D.2 consists of five serious injuries/incidents including UIRs 063, 077, 094, 127, and 150. The Monitoring Team also decided to review a sample of Facility investigations of non-serious unknown (discovered) injuries, referred to as the E.17 process. Investigation of nonserious injuries technically is outside the scope of SA requirements. Because discovered nonserious injuries can result from abusive acts the Monitoring Team feels it is important to review a sample of them to ensure they are adequately investigated, especially to rule out abuse or neglect as a contributing cause. RSSLC was recently cited by DADS regulatory with an Immediate Jeopardy and Condition of Participation level finding related to its failure to adequately investigate discovered injuries.This will be referred to as Sample D.3. This sample was reviewed for the E.17 process for Individuals #25, #641, #529, #592, and #315. The Facility established an Administrative Review Team to review all Client Injury Reports (CIRs) and Incident Information Reports (E.17s). This group meets twice a week. At the meeting attended by the Monitoring Team, documents were provided to members of the team to review (each member got a specific set of documents) and that member reported on any issues they identified with their assigned reports. This process is an additional process to the ordinary work processes that include document review and should result in improved performance. In reviewing Sample D.1 (DFPS case reports) two of six (33%) reported evidence that the initial report to DFPS did not occur within one hour of discovery or suspicion of the incident leading to the report to DFPS. This was the case for DFPS investigations 38745482 and38855851 In reviewing Sample D.2 (serious injuries and incidents) three of five (60%) were reported immediately (within one hour) to the Facility Director/designee. Those that were not reported within one hour included UIRs 094, 127, and 150. Discovered injuries per Policy E.17 are to be reported to the Home or Area Supervisor, or Campus Coordinator in off hours. In reviewing Sample D.3 the Monitoring Team did not identify any place on the Incident Information Report to document this notification occurred. The E.17 reports the date and time of incident. This could be presumed to be the date and time the injury was discovered. The E.17 notes "reported by" which could be presumed to be the person who discovered the injury. Neither presumption may be	

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		accurate. Therefore it is not possible to determine who reported what to whom when. The E.17form should be labeled in a more descriptive manner and/or the form should include instructions that clearly describe the information that is intended to be recorded in each section of the form. Through the course of reviewing investigations the Monitoring Team noted that the video surveillance cameras that have been in operation since 1/3/11 have been helpful in ascertaining the facts associated with some allegations.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team found that policy needs to be revised to address the requirements of this provision but that the Facility did take the required actions, and therefore has determined this provision is in substantial compliance. RSSLC policies A.17 Managing Unusual Incidents, andC.2 Actions Following Report of Abuse, Neglect, Exploitationare intended to address this requirement of the SA. These policies do not adequately address this component of this provision of the SA. For example, policy A.17 Managing Unusual Incidents (which includes serious injuries) does not provide any directions relative to the protection of the individuals involved in a serious incident. The policy identifies 13 related policies, most of which, at least by the title of the policy, are not likely to include specific client protection instructions; for example, one of the referenced related policies is policy D.8. , Completing/Routing Client Injury Report. Policy C.2 Actions Following Report of Abuse, Neglect, Exploitation provides a range of client protection measures that can be taken following an allegation. This includes removing an alleged perpetrator from direct contact with individuals pending the investigation's outcome. This action is discretionary per the policy although in practice it appears that in all instances where alleged perpetrators were known or identified in the course of an investigation, they were removed from direct contact. Files reviewed by the Monitoring Team confirmed this and the IMC reports this is the practice in 100% of cases. Based on a review of six investigation reports included in Sample D.1 in every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no contact status. Review of six investigation files included in Sample D.1 showed there were no instances where staff that had been removed from direct contact and subsequently reinstated after a well-supported preliminary assessment that the employee posed a risk to individuals	Substantial Compliance

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		or the integrity of the investigation. Based on a review of the six investigation files in Sample D.1, it was documented that additional action was taken to protect individuals in each case. For example: nursing assessments were done and treatment rendered as appropriate, alleged perpetrators were put in NDC (No Direct Care) status, and emotional assessments of victim trauma were conducted by psychology staff. Increased monitoring of a residential area is often part of an immediate protection plan following an allegation of abuse. It was surprising to the Monitoring Team that none of the investigations reviewed indicated increased monitoring as part of an immediate protection plan. Similarly, immediate retraining of certain staff is often part of an immediate protection plan following an allegation of neglect. This did not occur as part of an immediate protection plan in any of the investigations reviewed. The Monitoring Team suggests RSSLC address the policy clarifications to ensure policies support, guide, and ensure maintenance of procedures that are in compliance.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs because 28% of the staff training records in the sample reported staff was not current in Unusual Incident (UNU0100) training. Training in unusual incidents must be kept current. It is one of the most fundamental policies associated with a client protection system. RSSLC Policy C.1 Reporting Abuse, Neglect, Exploitation is intended to address this requirement of the SA. This policy does not specify specific classes that are to be successfully completed to demonstrate competency. The Monitoring Team has determined that successful completion of class ABU0100 Abuse and Neglect, andclass UNU0100 Unusual Incidents at least yearly are sufficient to demonstrate compliance with the SA. A review of the training curricula related to abuse and neglect was carried out for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: In relation to the requirement that training is competency-based, the material reviewed included provisions for trainees to demonstrate their understanding of what constitutes abuse, neglect, and exploitation and how to report observations or suspicion of abuse, neglect, or exploitation. The material also included adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation.	Noncompliance

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		Review of 25 staff records (Sample C.2), showed that 25 (100%) of these staff had completed competency-based training on abuse and neglect and unusual incidents prior to working directly with individuals. All 25 (100%) staff had completed Abuse and Neglect training within the last 12 months. Seven(28%) had not completed Unusual Incident training within the last 12 months and therefore were not compliant with the SA requirement of yearly training. Based on an interview of 10 staff responsible for the provision of supports to individuals, ▪ Eight (80%) were able to list signs and symptoms of abuse, neglect, and/or exploitation with sufficient depth to demonstrate competency of understanding; and ▪ Nine (90%) were able to describe the complete reporting procedures for abuse, neglect, and/or exploitation.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur. In the first compliance review the Monitoring Team had rated this provision as being in substantial compliance. During this review the Monitoring Team determined that in most instances the Facility did not use the document required by State policy (form 1020) and the RSSLC document that was used did not contain equivalent information. In addition, in a sample of employees,the Facility was unable to produce either document for 12% of the sample. RSSLC policy C.1 Reporting Abuse, Neglect, Exploitation includes provisions that address this requirement of the SA. The policy requires use of an RSSLC document with no reference to the acknowledgement document (form 1020) required by State policy. The Facility did not consistently use the acknowledgement form 1020 required by State policy to demonstrate compliance with this component of the SA. A RSSLC form entitled "Acknowledgement of RSSLC Employee Responsibility for Reporting Abuse/Neglect/Exploitation Incidents" (dated 12/15/09) was apparently used as an alternative. While this document contained useful information not found in the 1020, such as directions to call DFPS and the phone number, it did not contain important information that is included on the 1020, particularly the eight examples of activity that would represent acts of abuse, neglect, or exploitation. The Monitoring Team did not view the RSSLC form as equivalent to the State form 1020. Copies were requested of the forms for staff hired during the two full months prior to the	Noncompliance

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		on-site review. Based on a review of the forms provided to the Monitoring Team,none of the 59 recently hired staff had signed the DADS required acknowledgement form 1020. This is the form required by DADS policy to document compliance with this component of the SA. All 59 (100%) had completed the RSSLC form. A sample of 25 staff (Sample C.2)was randomly selected to determine if annual acknowledgements had been signed. Twelve (48%) had current signed 1020 acknowledgement statements. Ten (40%) had The RSSLC form and three (12%) had neither form. The Facility reported four instances where a mandatory reporter failed to report abuse or neglect. This was identified in UIRs 11-079, 084, 091, and 144. Appropriate personnel action was taken in each case. Facility administrative staff reported that there were no instances of late reporting although the Monitoring Team found several instances. For example, in reviewing Sample D.1 (DFPS case reports) two of six (33%) reported evidence that the initial report to DFPS did not occur within one hour of discovery or suspicion of the incident leading to the report to DFPS. This was the case for DFPS investigations 38745482 and38855851. In reviewing Sample D.2 (serious injuries and incidents) three of five (60%) were reported immediately (within one hour) to the Facility Director/designee. Those that were not reported within one hour included UIRs 094, 127, and 150. In these instances appropriate personnel action was taken and documented by the facility.	
	(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.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. RSSLC policy C.1 Reporting Abuse, Neglect, Exploitation would be one of the Facility policies that would be expected to include provisions that address this requirement of the SA. The Monitoring Team did not identify language in this policy that addressed this topic. Policies at other SSLC's usually are organized in a manner where there is a topical heading that addresses the subject matter of each requirement of the settlement agreement, under which the Facility articulates the policy and practices relevant to that requirement of the SA. RSSLC Policy F.1 Scheduling Annual Personal Support Plan Meetings includes a provision that the PSP invitation letter to Primary Correspondents is to include the recognizing abuse and neglect brochure and a rights booklet. Limited effort was directed at informing individuals, guardians, and LARs of abuse reporting responsibilities and procedures. Materials are provided to LARs prior to each	Noncompliance

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		individual's PSP meeting. The Monitoring Team members attended several PSP meetings during the review week. These are identified in other sections of this report. None of these meetings included any substantive discussion of abuse, neglect or other reportable incidents. A review by the Monitoring Team of the minutes of the four most recent self-advocacy group meetings, and observation of the meeting held the week of the review, did not reflect any presentation or discussion of abuse/neglect and reporting procedures. The Human Rights Officer, who facilitated the meeting, stated that there had been such discussions, and that individuals usually can tell what to do, but he agreed they did not do so at this meeting. The absence of a robust set of activity to educate individuals, guardians, and LARs of abuse/neglect and reporting procedures is inconsistent with a commitment to not tolerate abuse and neglect. In interviewing a sample of two individuals living at RSSLC, they were, after considerable prompting, able to describe what they would do if someone hurt them, or they had a problem with which they needed help. Despite the lack of robust effort directed at this component of the SA, six allegations were identified by the facility as incidents reported by an individual, guardian, or LAR. These were UIRs 052, 055, 059, 096, 105, and 134. Four of these were allegations of neglect, two of which were confirmed. Two were unconfirmed allegations of abuse.	
	(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.	In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur. In the first compliance review the Monitoring Team had rated this provision as being in substantial compliance. The Monitoring Team observed several instances where postings were not in place, were not displayed prominently, or were in poor condition. Additionally the Facility could not provide adequate documentation of its monitoring for compliance with this component of the SA. RSSLC policy C.1 Reporting Abuse, Neglect, Exploitation would be one of the Facility policies that would be expected to include provisions that address this requirement of the SA. The Monitoring Team did not identify language in this policy that addressed this topic. Policies at other SSLC's usually are organized in a manner where there is a topical heading that addresses the subject matter of each requirement of the settlement agreement, under which the Facility articulates the policy and practices relevant to that requirement of the SA. A review was completed of the postings the Facility used. The Facility uses two posters. One is primarily designed to inform individuals (and staff) of rights, including the right to be free from abuse and neglect. The other is designed to inform individuals (and staff) of abuse/neglect reporting procedures (which would include prominent display of the	Noncompliance

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		DFPS 1-800 number). The content of the two posters is acceptable to the Monitoring Team. Observations by the Monitoring Team of living units and day programs on campus showed that most environments had postings of individuals' rights in an area to which individuals regularly had access. The Monitoring Team observed several instances where postings were not in place, were not displayed prominently, or were in poor condition. An example of this was observations made in Leon C on 5/11/11. In this instance there was no abuse reporting poster in an area visible to individuals. The Monitoring Team expects both posters to be prominently displayed in areas used by individuals (e.g. Living room, dining room, etc.) and by staff (e.g. medication room, area where staff sign in/out, etc.). The Facility had an auditing process that included checking on the proper display of these posters. Results of these audits presented to the Monitoring Team were inadequate; for example, in response to a request for a document indicating the locations that were checked to ensure posters were in place, a copy of the facility map was provided. When asked for a copy of a report or any other document that would validate the auditing, such as an email to a supervisor summarizing the result of auditing, none were produced by the Facility.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement.The Monitoring Team does not concur. In the first compliance review the Monitoring Team had rated this provision as being in substantial compliance. Procedures, as required by the SA, were in place. These procedures are intended to refer "as appropriate" and the Monitoring Team identified two cases (of six) where it appears law enforcement referral should have been considered and, at least in the material provided to the Monitoring Team, was not. The policy should provide greater specificity on what must be referred. Because these implementation issues were identified during this review the Monitoring Team cannot validate substantial compliance in this review. RSSLC Policy A.17 Managing Unusual Incidents and C.2 Actions Following Report of Abuse, Neglect, Exploitation would be expected to address this requirement of the SA. The Monitoring Team did not identify language in either policy that addressed this topic. Policies at other SSLC's usually are organized in a manner where there is a topical heading that addresses the subject matter of each requirement of the settlement agreement, under which the Facility articulates its policy and practices relevant to that requirement of the SA. In this component of the SA, ordinarily the Facility would describe the process by which it reports allegations to DFPS and DFPS determines if the allegation	Noncompliance

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		is appropriate for law enforcement (Office of Inspector General or local law enforcement) referral. Information to this effect is ordinarily noted on the DFPS case report. The Facility policy might also describe other circumstances in which it refers allegations directly to law enforcement, such as incidents that do not involve abuse or neglect but may represent criminal activity, such as theft or employee to employee assault or a particularly egregious abuse case requiring immediate law enforcement response. Based on a review of six allegation investigations completed by DFPS (Sample D.1), DFPS had made law enforcement referrals in 1 case (38855851). This was a case of unconfirmed abuse. The remaining five cases included two confirmed abuse cases, two confirmed neglect cases, and one unconfirmed neglect case. In reviewing the circumstances of the two confirmed abuse cases it appears to the Monitoring Team that case 38798375 should have been referred to law enforcement as the DFPS investigator determined the individual "was hit by her (the alleged perpetrator) and she continued to go after him." The DFPS investigator viewed the testimony of the individual (victim) as credible. It also appears to the Monitoring Team that case 38592634 should have been referred to law enforcement as the DFPS investigator determined that the alleged perpetrator (AP) "hit the individual on the left side of his neck head area and swung at the individual two more times", and, that the AP "grabbed the individual behind the back of the neck pushing him into the wall." These are examples of the types of case that should be referred to law enforcement for consideration for arrest and/or prosecution even if the AP's no longer work for the Facility. In the first case the victim was viewed as credible. In the second case, the victim was non-verbal but there was a substantial amount of corroborating evidence presented in the case report. Following the visit and notice to the Facility of the finding that not all investigations that should have been reported to law enforcement had been reported, the Monitoring Team was informed that DFPS had reviewed these investigations, agreed with the finding, and planned to discuss this with regional staff to ensure policy compliance. If referrals are not made by DFPS as an investigation begins or during the course of the investigation, the Facility should consider referral when it is reviewing the case disposition report from DFPS. Even if past history suggests law enforcement is not likely to pursue investigation, arrest, or prosecution, it is important that staff understand that abuse is against the law and if you engage in such acts there is potentially more at stake than just loss of employment. This is a proactive approach to abuse/neglect prevention. Based on a review of 10 investigations completed by the Facility (Samples D.2 and D.3),	

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		law enforcement referral was not necessary or appropriate given the nature of the incident being investigated and the facts discovered during the course of the RSSLC investigation.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur and has determined the Facility to be in substantial compliance with this component of the SA. There were some issues with staff knowledge and the Facility should ensure it continues to train and spot test staff knowledge through its QA auditing to ensure this component stays in compliance. RSSLC C.1 Reporting Abuse, Neglect, Exploitation addresses this component of the SA. Based on interviews with the Facility administrative staff, including the Incident Management Coordinator, it was evident retaliation would not be tolerated, and this was reinforced in training and during the course of individual investigations. The IMC reported he places particular emphasis on this in the abuse and neglect training class he conducts. In interviewing a sample of two individuals, they were, after considerable prompting, able to describe what they would do if someone hurt them, or they had a problem with which they needed help. Neither understood the concept of retaliation. Based on an interview of 10 staff responsible for the provision of supports to individuals, nine (90%) were clear in their understanding that retaliation was not tolerated by the facility administration. Seven (70%) reported that if retaliation occurred administration would take action. One of the three who did not think the administration would take action reported "they wouldn't do nothing," The Monitoring Team interviewed an OIG investigator and a DFPS investigator who happened to be at the Facility conducting investigations. Both were asked if they had discovered in their investigation activity any instances of actual or perceived retaliation against reporters. They both indicated they had not. These responses supported the reports of most staff that retaliation was not tolerated. Based on a review of investigation records (Samples D.1, D.2, and D.3), there were noconcerns noted related to potential retaliation. The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who had in good faith had reported an allegation of abuse/neglect/exploitation. The Facility indicated it	Substantial Compliance

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		did not have such a list because there were no incidents of perceived or actual retaliation reported.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. None of the RSSLC policies reviewed by the Monitoring Team addressed this requirement of SA. The POI reports that as of 1/3/11 "audits are completed monthly to review all serious injuries and to determine if they have been reported via E.17 and/or UIR for investigation by comparing the UIR data base and the CIR data base." The POI further states that as of 3/1/11 "Campus Investigators review the home logs to determine if all CIRs have been reported to the Campus Coordinators to insure investigations of unknown injuries have been reported for investigations." During the review the Monitoring Team afforded the Facility the opportunity to provide a description, with accompanying documents, of what the Facility thought it was doing to address this requirement of the SA, including any reports the process may have generated. The information provided consisted of a process whereby campus coordinators review Home Shift Monitoring Logs and validate that incident reports were initiated for any event appearing to require one. This can be part of an audit process but needs improvement. An under-reporting audit process should also consist of reviews of integrated progress notes, nursing notes, and other relevant data sources to determine if any information in those documents should have generated an incident report and did not. Additionally, for an audit process to meet the requirements of the SA it must have a degree of formality in its organization and include written methodology, specification of who audits what and at what frequency, sample size, staff assigned to audit, follow-up required when issues are identified, validation that follow-up occurred, and, whether or not the validated follow-up was satisfactory. The process should also present a periodic written report summarizing the process and audit results.	Noncompliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. Some elements of RSSLC policies A.17 Managing Unusual Incidents, A.25 Securing Evidence, B.15 Taking Disciplinary Action Following Confirmed Abuse, Neglect, or Exploitation, B.26 Placing an Employee on Investigative Leave, C.0 Video Surveillance, C.1 Reporting Abuse, Neglect, Exploitation, C.2 Actions Following Report of Abuse, Neglect,	

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	injury, and other serious incidents involving Facility residents. Such policies and procedures shall:	Exploitation, C.3 Actions Following Investigation of Abuse, Neglect, Exploitation, D.8 Completing/Routing Client Injury Report, E.10 Participating in Unit Morning Meeting, and E.17 Completing Incident Information Reports would be expected to address this provision of the SA. RSSLC policies are in need of a major overhaul. The policies are difficult to follow and several can be combined for ease of understanding and administration. The policies should be structured in a more organized manner using a standard methodology for compartmentalizing information using an outline format. The RSSLC policies referenced in this section seldom had clear policy related statements. Policies at other SSLC's usually are organized in a manner where there is a topical heading that addresses the subject matter of each requirement of the settlement agreement, under which the Facility articulates its policy and practices relevant to that requirement of the SA. This format at other facilities seems to allow the Facility to ensure work efforts and resources that they expect will lead to substantial compliance are directed at identified SA requirements.	
	(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.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. The POI reports that all campus investigators had completed Root Cause Analysis training but no documentation to this effect was provided to the Monitoring Team. Some elements of RSSLC policies A.17 Managing Unusual Incidents, A.25 Securing Evidence, B.15 Taking Disciplinary Action Following Confirmed Abuse, Neglect, or Exploitation, B.26 Placing an Employee on Investigative Leave, C.0 Video Surveillance, C.1 Reporting Abuse, Neglect, Exploitation, C.2 Actions Following Report of Abuse, Neglect, Exploitation, C.3 Actions Following Investigation of Abuse, Neglect, Exploitation, D.8 Completing/Routing Client Injury Report, E.10 Participating in Unit Morning Meeting, and E.17 Completing Incident Information Reports would be expected to address this provision of the SA. The Monitoring Team did not identify language in policy A.17, C.2, or E.17 that required that investigations be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator. The Monitoring Team did not identify language in policy A.17, C.2, or E.17 that required that investigators be outside of the direct line of supervision of the alleged perpetrator. None of the RSSLC policies directed at investigations identified the training requirements expected of staff designated as investigators. Additionally, policies directed at the "conduct of the investigation" were unclear. For the	Noncompliance

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		most part the policies described a series of steps to be taken by various staff to process the unusual incident through the administrative system. Missing from the policy was descriptive information on the conduct of the actual investigation of an incident by a qualified investigator. Policy E.17, which addresses nonserious injuries, provides some direction on how to properly complete the E.17 document. It did not provide direction on how to conduct an investigation. Some entries on the E.17 form require asking questions such as "Was incident related to the individual's behavior related, if so describe", If yes, please describe the behavior", Is there a Positive Behavior Support (PBS)". This may be helpful in properly completing the E.17 form, and as a probe for asking certain questions, but it is insufficient to meet this requirement of the SA. Policies at other SSLCs usually are organized in a manner where there is a topical heading that addresses the subject matter of each requirement of the settlement agreement, under which the Facility articulates its policy and practices relevant to that requirement of the SA. In this component of the SA, ordinarily the Facility would describe the process by which it conducts an investigation, including a description of who can conduct an investigation, the training that is required for the designated staff to This is be considered qualified, basic steps of investigatory protocol used by an investigator, and organizational placement that addresses the line of supervision requirement. The Monitoring Team did not review curricula used by DFPS in training its investigators and cannot comment on its content and whether or not it is competency based. Because DFPS case investigations reviewed by the Monitoring Team were generally thorough and comprehensive and case reports were generally well written, the Monitoring Team believes, at least for now, the training DFPS investigators received is achieving the desired results. DFPS reports its investigators are to have completed APS Facility BSD 1 & 2, or MH &MR Investigations ILSD and ILASD depending on their date of hire. While not required it appears many investigators also take a class titled "MH&MR Overview – APS Investigator Role", and/or "Back to Basics for MH&MR Investigators." Completion of these classes' would demonstrate training in working with people with developmental disabilities. DFPS hadnine investigators assigned to work RSSLC cases.The training records for these investigators were reviewed. All nine (100%) had completed the requirements for investigations training. RSSLC policies did not specify specific training classes required for investigators. In the absence of policy definition, the Monitoring Team chose to review based on	

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		requirements identified in policy from other SSLCs. As a result the Monitoring Team expects RSSLC investigators to have completed the following training classes: 1. ABU0100 Abuse and Neglect 2. UNU0100 Unusual Incidents 3. CIT0100 Comprehensive Investigator Training 4. MEN0300 People with Mental Retardation 5. LRA training Fundamentals of Investigations and Conducting Serious Investigations (CSI0100 and INV0100) 6. Training in Root Cause Analysis. The Monitoring Team believes this training, if completed as described, should be adequate for the conduct of investigations at RSSLC. RSSLC had seven staff designated as investigators. The training records provided by the training department for these staff were reviewed. These records show that none of the RSSLC investigators (0%) had completed all the required training. 1. All had completed ABU0100 Abuse and Neglect. 2. All had completed MEN0300 People with Mental Retardation. 3. Two (29%) of seven had completed CIT0100 Comprehensive Investigator Training. 4. Six (86%) had completed LRA training Fundamentals of Investigations and Conducting Serious Investigations (CSI0100 and INV0100). One investigator had completed CSI0100 but had not completed INV0100. 5. None (0%) had completed training in Root Cause Analysis. 6. Five (71%) were current in UNU0100 Unusual Incidents. The other two investigators had completed this class but not within the last 12 months as required by State policy. None of the staff designated as investigators had supervisory responsibilities that extend beyond the Incident/Risk Management Department; therefore,they are unlikely to be in the direct line of supervision of anyone subject to investigation.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. The only reference to this issue found by the Monitoring Team is in policy C.1 which included the following language in a section on new employee orientation and annual refreshers: 1. An explanation that an employee must cooperate with investigators from DFPS and DADS in all matters related to investigations of abuse, neglect, or	Substantial Compliance

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		exploitation allegations, including that an employee who fails to cooperate with an investigation is subject to disciplinary action up to and including dismissal. 2. An explanation that an employee is encouraged to cooperate with local law enforcement officers and the Office of Inspector General (OIG) investigators during the course of their investigations. RSSLC should be clearer in articulating its policy that is designed to comply with this requirement of the SA. An example of requirements that might be appropriate in a RSSLC policy in an assurances section of an abuse, neglect, exploitation policy, or a state center investigations section of an incident management policy might be: 1. Language that requires employees and agents to cooperate with DFPS investigators so that they are afforded immediate access to all records and evidence as necessary to conduct an investigation in a timely manner. 2. Language that requires administrative staff to assist in whatever way possible to make employees and agents who are relevant to the investigation available in an expeditious manner. 3. Language that makes it known thatstaff failure to cooperate with an investigation will result in disciplinary action. Training and other administrative activity would reinforce these principles. Referencing the principles of cooperation with law enforcement in a section of a policy describing new employee orientation is insufficient. Despite the lack of a policy requirement the Monitoring Team did not find any instances of lack of cooperation in its review of the six DFPS investigations in Sample D.1. Additionally, the Facility produced several very good examples of cooperation with law enforcement. These were noted in UIRs 031, 055, 062, 079, and 091. Additionally, the Monitoring Team would like to commend the RSSLC for convening periodic joint meetings with DFPS and OIG at which any issues of mutual cooperation can be reviewed and resolved. The Monitoring Team reviewed the minutes of this meeting which was held on 4/21/11. The Monitoring Team interviewed an OIG investigator and a DFPS investigator who happened to be at the facility conducting investigations. Both were asked if they had any issues with cooperation of facility administrative staff; protection of evidence (if applicable); cooperation of alleged perpetrators and witnesses; and, if through their investigations they had discovered any instances of actual or perceived retaliation against reporters. Both were very complimentary of RSSLC, particularly the IMC, in the degree of cooperation received and the professionalism demonstrated by the IMC and his staff.	

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		The Monitoring Team suggests RSSLC address the policy clarificationsto ensure policies support, guide, and ensure maintenance of procedures that are in compliance.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	RSSLC In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. Despite the lack of policy direction, the Monitoring Team did not find any issues with lack of coordination with law enforcement agencies. In fact, in an interview with an OIG investigator the level of cooperation from the IMC and other administrative staff was characterized as exceptional. A Memorandum of Understanding including multiple agencies with potential law enforcement roles, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy 002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ In 6 of 6 (100%) investigation records from DFPS (Sample D.1) no evidence of interference by one agency or the other was identified. Of the five investigation records from the Facility (Samples D.2.), none had been referred to law enforcement agencies. These were serious incidents, including some injuries, where there was no suspicion of abuse or neglect, and therefore would not be reported to DFPS or law enforcement. The Monitoring Team interviewed an OIG investigator and a DFPS investigator who happened to be at the facility conducting investigations. Both were asked if they had any issues with cooperation of facility administrative staff, protection of evidence (if applicable), and, cooperation of alleged perpetrators and witnesses. Both were very complimentary of RSSLC, in the degree of cooperation received and the professionalism demonstrated by the IMC and his staff.	Substantial Compliance

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		The Monitoring Team suggests RSSLC address the policy clarifications to ensure policies support, guide, and ensure maintenance of procedures that are in compliance.	
	(d) Provide for the safeguarding of evidence.	In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. While on site, the Monitoring Team observed the area the Facility uses for safeguarding evidence as well as actual evidence secured in a locked file cabinet in the locked office of the Incident Manager's office. Based on a review of the investigations completed by DFPS (Sample D.1) and the Facility (Sample D.2) any evidence that needed to be safeguarded was. The Monitoring Team interviewed an OIG investigator and a DFPS investigator who happened to be at the facility conducting investigations. Both were asked if they had any issues regarding protection of evidence. They did not and were very complimentary of RSSLC, particularly the IMC, in the degree of cooperation received and the professionalism demonstrated by the IMC and his staff The Monitoring Team suggests RSSLC address the policy clarifications to ensure policies support, guide, and ensure maintenance of procedures that are in compliance.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. The policies do not define any clear definition of the term "serious incident" nor are they structured in a way that describes a process that would lead to compliance with this component of the SA. The Monitoring Team would expect Policy A.17 Managing Unusual Incidents to address this component of the SA. There is no language that requires 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 Director or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. Please refer to other components of Section D for comments regarding the need for RSSLC policies to be revised. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were	Noncompliance

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		reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations (Sample D.1)</u> The following summarizes the results of the review of the six DFPS investigations in the sample: None (0%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information, if any, included in the investigative report that described the steps taken to determine the priority of investigation tasks, as well as any documentationprovided regarding any substantive investigatory tasks that were undertaken within 24 hours of DFPS being notified of the allegation. The following are examples where the investigations for which adequate investigatory process did not occur within the first 24 hours or sooner: 1. Investigation 38798375 was reported to DFPS at 10:30pm on 3/21/11. The initial face-to-face interview with the alleged victim did not occur until 3/24/11 at 9:07am. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. This was a case of confirmed physical abuse. 2. Investigation 38745482 was reported to DFPS at 6:30am on 3/16/11. The initial face-to-face interview with the alleged victim did not occur until 3/18/11 at 10:53am. The investigator attempted to visit the victim (who was in the hospital) on 3/17/11at 10:42am but was unable to because the individual was at another part of the hospital for a medical procedure. The first interview with any RSSLC staff did not occur until 3/21/11. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. This was a case of confirmed neglect. 3. Investigation 38843655 was reported to DFPS at 12:04pm on 3/27/11. The initial face-to-face interview with the alleged victim was on 3/30/11 at 10:15am. DFPS was waiting to initiate an investigation pending feedback from OIG as to whether or not they were going to investigate. OIG notified DFPS on 3/28/11 at 10:17am. The initiation of the investigation by DFPS did not occur until 3/30/11. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. This was a case of confirmed neglect. All six (100%) were completed within 10 calendar days of the incident. All six (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation	

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		findings are discussed below with regard to Section D.3.f of the Settlement Agreement. In all six (100%) DFPS concerns and recommendations for corrective action were included. In all six the recommendations were appropriate to address issues identified by the DFPS investigator. <u>Facility Investigations (Sample D.2.a)</u> The following summarizes the results of the review of Facility investigations of serious incidents: Three of six (50%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing the UIR section 7 "Chronology of the Incident/Injury" and determining the time of the first entry indicating any on site work activity by a facility investigator. The three incidents that did not meet the 24 hour criteria are: 1. UIR-063 - no information was reported in section 7 that would validate a facility investigator conducted this investigation. 2. UIR-094-ingestion of a foreign object (PICA) was reported to the facility Nurse Practitioner on 1/30/11. This incident was apparently not reported to the IMC until 2/2/11 at which time the investigation was initiated. The investigation did not occur within 24 hours of the incident. 3. UIR-150 - no information was reported in section 7 that would validate a facility investigator conducted this investigation. Three of six (50%) were completed within 10 calendar days of the incident, including sign-off by the supervisor (IMC). The investigations that did not meet this criterion were UIR 094 (incident date of 2/2/11 – IMC sign-off 2/17/11), UIR 127 (incident date 3/14/11 – IMC sign-off date 4/18/11), and UIR 150 (incident date 4/12/11 –no IMC signoff date although the investigator signed off on 4/25/11). Five of six (83%) resulted in a written report that included a summary of the investigation findings. UIR 150 did not include a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. Five of six (83%) included recommendations for corrective action.UIR 150 did not.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. Although policy did not address all the requirements of this component, as noted in the	Noncompliance

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	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.	finding for component D3(a), contents of most investigation reports reviewed were sufficient to provide a clear basis for conclusions.The reports utilized a standardized format that sets forth explicitly and separately: • Each serious incident or allegations 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. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • In six of six investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately o In 6 (100%), each serious incident or allegations of wrongdoing; o In 6 (100%), the name(s) of all witnesses; o In 6 (100%), the name(s) of all alleged victims and perpetrators; o In 6 (100%), the names of all persons interviewed during the investigation; o In 6 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 6 (100%), all documents reviewed during the investigation; o In 6 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In 6(100%), the investigator's findings; and	

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		o In 6(100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: • In four of five investigations reviewed (80%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The investigation that did not was UIR-150. • The report utilized a standardized format that set forth explicitly and separately: o In 5(100%), each serious incident or allegations of wrongdoing; o In 5 (100%), the name(s) of all witnesses; o In 5 (100%), the name(s) of all alleged victims and perpetrators; o In 5 (100%), the names of all persons interviewed during the investigation; o In none (0%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 5 (100%), all documents reviewed during the investigation; o In 5 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency o In 4 (80%), the investigator's findings. The investigation that did not was UIR-150. o In 4 (80%), the investigator's reasons for his/her conclusions. The investigation that did not was UIR-150. The lack of information about interviews for Facility investigations and the lack of findings in one Facility investigation, in addition to the lack of clear policy, results in a finding of noncompliance.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. A revised policy should require that staff supervising the investigations (the IMC) review each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete and coherent and that any further inquiries or deficiencies are addressed promptly. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed below, and the findings related to	Substantial Compliance

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		the DFPS investigations and the Facility investigations are discussed separately. DFPS Investigations The following summarizes the results of the review of DFPS investigations: • Five of the six (83%) case files reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. Case 38855851 did not. • In all five case files, there was evidence that the RSSLC Incident Manager Coordinator had conducted a review of the investigation report and that any concerns had been reported back to DFPS to correct deficiencies or complete further inquiry. Facility Investigations The following summarizes the results of the review of Facility investigations: • In all five investigation files reviewed there was evidence that the supervisor had conducted a review of the investigation report. • In four (80%) there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. The investigation that did not was UIR-150.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur. In the first compliance review the Monitoring Team had rated this provision as being in substantial compliance. During this review, the Monitoring Team determined that 50% of the sampled files did not contain a "DFPS Investigation Cover Sheet Allegation and Final Report", which was described by the Facility as the documentation that demonstrated compliance with this component of the SA. RSSLC Policy A.17 describes a routing process for the review of investigation reports. The policy did not include any language regarding what the review is to consist of (to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent and that any deficiencies or areas of further inquiry in the investigation and/or report are addressed promptly). RSSLC used the IMRT process to review the DFPS reports already reviewed by the IMC and used the minutes of that group to represent compliance with this component of this provision of the SA. This process is intended to ensure senior management of the Facility is involved in the review of each case. A concern of the Monitoring Team is that the members of the IMRT do not have access to the actual DFPS report when conducting this review. Rather, the IMRT relies almost exclusively on the verbal representations of	Noncompliance

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		report content presented by the Incident Management Coordinator. Concern with confidentiality may be a consideration in this regard; nevertheless, the Monitoring Team is of the opinion that at least some members of senior management, along with the IMC, should be part of a review team that assesses the adequacy of each DFPS report to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent and that deficiencies or areas of further inquiry in the investigation and/or report are addressed promptly.A process similar to this is in place at most other facilities this Monitoring Team has reviewed. RSSLC used a form "DFPS Investigation Cover Sheet Allegation and Final Report", dated 3/22/11, that documents review of each DFPS investigation report by the IMRT. This document includes a space to note any recommendations that are made by the IMRT and note the disposition of alleged perpetrators. In the files prepared by the Facility for the Monitoring Team, this document was present in three (50%) of six cases. Those that did not contain this document were 38592634 (confirmed abuse), 38896039 (unconfirmed neglect), and 38855851 (unconfirmed abuse). The three cases that did include this document noted the date of IMRT review. None of the three noted any recommendations. None of the files prepared by the Facility contained a copy of the IMRT meeting minutes at which the review occurred. The Monitoring Team is concerned that reviews by the IMRT are perfunctory in nature and do not serve the intended purpose of ensuring an adequate and thorough review of investigations.	
	(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.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. The Facility reported in the POI that "all information is tracked in the UIR follow-up section." This is insufficient to demonstrate compliance with this component of the SA. In reviewing the follow-up actions for the six DFPS cases, actions were identified with a person responsible and a target date noted. There was not any notation on any of the six UIRs that the intended follow-up occurred, and when, and whether or not it was effective. Additionally, follow-up actions noted on the UIRs did not, for the most part, reflect the type of thoughtful discussion and consideration that is necessary to correct the situation and/or prevent recurrence. The complete listing of recommendations for current/future actions (item 13 on the UIR document) from the six DFPS cases in the Sample are presented below: 1. Staff will face a 10 day suspension 2. Termination of employment per A/N policy (2x) 3. Follow-up psychological assessment will be conducted 4. Performance counseling for staff (2x) 5. Staff will be re-inserviced	Noncompliance

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		6. AP resigned Even if the recommendations recorded on UIRs were of sufficient scope and depth to be indicative of thoughtful analysis, the Facility did not have a tracking system that placed all recommendations in one location. This is necessary to enable effective monitoring of recommended actions. Finally, the Facility must place attention on the final two words of this component of the SA, "corresponding outcomes." A purpose of this review activity, and corresponding development of action plans, is to facilitate improved outcomes for the individuals living at RSSLC. For example, if a recommendation is "follow-up psychological assessment will be conducted" the tracking system should identify more data than just it did or didn't happen. This is not necessarily tracking that should be done in the office of the IMC but should be done somewhere. After all, the purpose of all this work is to make life better for individuals living at the RSSLC. The Facility produced a computer-generated report of terminated staff from 1/1/11 to 5/2/11. From this the Monitoring Team was able to validate that staff found to have committed abuse no longer worked at the Facility. Case files reviewed by the Monitoring Team included copies of all relevant disciplinary action taken in response to investigation findings.	
	(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.	In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. Data systems at the RSSLC enable an investigator to quickly identify individuals and staff who have been the subject of prior investigations. File storage in the IMC's office was organized and up-to-date. The Monitoring Team did not probe whether DFPS had a similar process by which it can quickly access prior history of alleged perpetrators although it is presumed they could obtain those data from the Facility database if necessary. The Monitoring Team suggests RSSLC address the policy clarifications to ensure policies support, guide, and ensure maintenance of procedures that are in compliance.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. Some elements of RSSLC policies A.17 Managing Unusual Incidents, A.25 Securing	Noncompliance

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	unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	Evidence, B.15 Taking Disciplinary Action Following Confirmed Abuse, Neglect, or Exploitation, B.26 Placing an Employee on Investigative Leave, C.0 Video Surveillance, C.1 Reporting Abuse, Neglect, Exploitation, C.2 Actions Following Report of Abuse, Neglect, Exploitation, C.3 Actions Following Investigation of Abuse, Neglect, Exploitation, D.8 Completing/Routing Client Injury Report, E.10 Participating in Unit Morning Meeting, and E.17 Completing Incident Information Reports would be expected to address this provision of the SA. They did not. Refer to other components of Section D for comments regarding the need for RSSLC policies to be revised. RSSLC produced a monthly Allegations of Abuse/Neglect/Exploitation Trend Report and a monthly Unusual Incidents Trend Report. Type of incident and type of DFPS case were reported longitudinally, usually back to the start of the previous fiscal year. This facilitates trend analysis. The SA requires that trends also be tracked by staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation. This was not being done except for the current report month. In addition to displaying data for the current report month all data should be displayed for at least a rolling 12 month period in order to detect trends. Similarly, the outcomes of investigations are not delineated between abuse, neglect, and exploitation. Current month data on the report includes identification of type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigations. This provides a good snapshot of the current month; however, these data are not trended over time, such as a rolling 12 month period. The Monitoring Team believes they must be in order to achieve compliance with this provision of the SA and to provide the Facility with information it needs to identify issues to address so as to improve safety and services. More detailed trend data is necessary to facilitate effective analysis that can lead to improved practice and better outcomes for individuals. The RSSLC has hada Quality Assurance/Quality Improvement Council in place for several months. This group meets twice a month and consists primarily of senior level administrators and clinicians. The Monitoring Team observed a meeting of this group during the review. Some SA related data were presented at the meeting and there was some discussion, primarily "question and answer" dialogue, rather than more substantive "how do we improve" dialogue. As this QA/QI process matures it will be important that it generate process improvements within the organization.	
D5	Before permitting a staff person (whether full-time or part-time,	In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team	Substantial Compliance

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	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.	concurs. Some elements of RSSLC policies A.17 Managing Unusual Incidents, A.25 Securing Evidence, B.15 Taking Disciplinary Action Following Confirmed Abuse, Neglect, or Exploitation, B.26 Placing an Employee on Investigative Leave, C.0 Video Surveillance, C.1 Reporting Abuse, Neglect, Exploitation, C.2 Actions Following Report of Abuse, Neglect, Exploitation, C.3 Actions Following Investigation of Abuse, Neglect, Exploitation, D.8 Completing/Routing Client Injury Report, E.10 Participating in Unit Morning Meeting, and E.17 Completing Incident Information Reports would be expected to address this provision of the SA. They did not. Refer to other components of Section D for comments regarding the need for RSSLC policies to be revised. By statute and by State policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. This practice had been followed at RSSLC. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 25 employees confirmed that their required background checks were completed. A random sample of six volunteers who regularly work with individuals living at the RSSLC confirmed that their required background checks were completed. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of October, 2010. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. RSSLC policies are in need of a major overhaul. The policies are difficult to follow and several can be combined for ease of understanding and

administration. The Facility needs to critically examine the structure and content of its policies directed at compliance with this section of the SA and revise them as appropriate. Most SSLCs have two policies governing this section of the SA, 1) Abuse, Neglect, & Exploitation, and, 2) Incident Management. RSSLC would be well served to review policies from other SSLCs.

2. The Facility's Trend Analysis Report needs to be expanded to track additional data elements longitudinally. The report also needs to be sufficiently footnoted to enable anyone reviewing the report to properly interpret data.
3. The Facility needs to follow State policies and consistently use documents/forms that are provided in State policy.
4. The Facility needs to improve in consistent application of its policies related to the entire incident management process.
5. Improvement in timely initiation of investigations is needed.
6. The audit/monitoring process for ensuring compliance with the requirements associated with rights posters needs to be formalized.
7. The Facility needs to be more proactive in working with DFPS and OIG in determining physical abuse allegations for which law enforcement referral should be considered.
8. The audit process to determine under-reporting of injuries and other incidents needs improvement.
9. When it is identified that staff have failed to report a serious incident or allegation in a timely manner or do not understand their responsibilities for reporting, the Facility should evaluate reasons, and address the underlying issues.
10. The Facility should routinely test staff's competence regarding the reporting of unusual incidents and abuse and neglect by having supervisors quiz them regularly on what is expected.
11. The Facility should include the Resource Guide in the PSP development process, so that individual and those closest to him/her will be able to identify and report unusual incidents, including allegations of abuse, neglect, and exploitation.
12. The Facility should expand its efforts to conduct critical analysis of the trend data collected to determine if any actions should be taken, or action plans developed to address any underlying causes of trends identified.
13. The Facility should establish a more organized and formal process for tracking recommendations resulting from reviews of investigation reports.

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. RSSLC Plan of Improvement 4/18/11 2. DADS Policy 003-Quality Enhancement 3. RSSLC Section E Presentation Book 4. RSSLC Policy A.27 Quality Assurance/Quality Improvement Council 4/28/11(draft) 5. RSSLC Policy A.28 Quality Assurance Plan 4/28/11 (draft) 6. RSSLC Quality Assurance Plan Draft 7. Restraint Trend Report 3/31/11 8. Unusual Incidents Trend Report 3/31/11 9. Allegations Trend Report 3/31/11 10. Injury Trend Report 3/31/11 11. QA Monitoring tools for each provision of the SA 12. QA/QI Council Meeting Minutes for 2/8/11, 2/15/11, 2/22/11, 3/8/11, 3/22/11, and 4/5/11 13. Restraint Reduction Team Meeting minutes for 12/30/10, 1/27/11, 2/24/11, and 3/30/11 **People interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. Alice Ramirez, Data Analyst 3. Judy Miller, SA Coordinator 4. Reuben Muhammad, Incident Management Coordinator 5. Carol Agu, QMRP Services Director **Meetings attended/Observations:** 1. Incident Management Team Meeting (IMRT) 5/2/11 2. HRC meeting 5/5/11 3. Four Rivers Unit Morning Meeting 5/5/11 4. Quality Assurance/Quality Improvement (QA/QI) Council 5/3/11 5. Administrative Review Team 5/3/11 6. Active Treatment meeting 5/3/11 7. Meeting with QA Department Staff 5/4/11
	Facility Self-Assessment: In its POI the RSSLC reported that it is not yet in compliance with any of the five provisions of Section E of the SA. The Monitoring Team concurs. The POI reported that systems are in place that will lead to compliance in all five provisions but they all are in need of continued improvement, refinement, and consistent application. These include the continued development of a data system to support the monitoring activities and continue to focus on a more organized and uniform approach to monitoring which integrates the monitoring done at the department level with that done at the QA Department level.
	Summary of Monitor's Assessment: The RSSLC QA Department has developed several draft documents to

guide its work.

RSSLC Policy A.27 Quality Assurance/Quality Improvement Council has the stated purpose of:
"The purpose of the Quality Assurance/Quality Improvement Council is to review and oversee the facility's status in regard to:

1. Regulatory/Life Safety visits;
2. Annual Peer Audits;
3. Facility Support Performance Indicator internal controls audits; and
4. Settlement Agreement monitor visits"

RSSLC Policy A.27 goes on to describe a series of administrative and review activities the QA/QI Council is responsible for. Membership of the Council consists primarily of executive level administrative and clinical staff. The Monitoring Team finds it unusual that a QA/QI Council policy does not articulate a mission that focuses on improving the quality of life for the individuals living at RSSLC. The scope and depth of the membership would allow for this. The policy, as presently written, focuses the resources of the QA/QI Council members almost entirely on managerial oversight of various tasks to ensure they are getting done. The meeting observed by the Monitoring Team served to validate this observation. RSSLC leadership may wish to engage in a heightened level of accountability activity requiring supervisors and managers throughout the organization to be strictly accountable for the work tasks assigned, so the QA/QI Council can direct its energy to data review, analysis, and development of action plans that are directed towards systemic or underlying causes of problems. The Monitoring Team understands this is a new and evolving process for the RSSLC and is hopeful that as the process matures it can find ways to review all data derived from all the tasks that are being done with a focus on the ways in which these data can be used to identify systemic and underlying causes of problems. The QA/QI Council could then focus its energy and resources on resolving these problems and planning and tracking initiatives to improve lives of people served by the Facility.

RSSLC Policy A.28 Quality Assurance Plan has the stated purpose of: "The policy establishes a planned, systematic, organization-wide approach to monitoring, analyzing, and continually improving the quality of care and services provided to individuals served at the RSSLC. RSSLC implements quality assurance processes consist with current, generally accepted professional standards of care that detect problems with the provision of protections, services and supports, and ensures appropriate corrective action is implemented and results improve services and supports."

The Quality Assurance Plan Draft, still under development, is in a matrix format and when complete will display what is to be monitored, who does the monitoring, what monitoring tools are to be used, the frequency of monitoring, the sample size and type, how and who aggregates data and generates reports, who and how the data is analyzed, and who reviews the analysis of the data. All this would be done, presumably, to lead to the development of action plans that are directed towards systemic or underlying causes of problems.

The QA Department has established three Engagement/Active Treatment Teams comprised of five mock

	survey trainers (a Program Auditor, an Active Treatment Manager, a Vocational Director, a Behavior Analyst, and a QMRP), three Program Monitors, the Director of Residential Services, and the Director of Quality Assurance.These teams are to coach/train staff in active treatment philosophy and activities unique to individuals. It is anticipated that this initiative will lead to improved engagement between staff and individuals living at the RSSLC. This process was put in place in recognition of deficient practices with respect to meaningful and ongoing engagement of individuals receiving services (continuous active treatment). This model may be worth replicating as the QA process identifies other areas of deficient practices. From its review the Monitoring Team was able to determine that QA systems are in place and are in various stages of development, refinement, and maturation, including the development of a data system that can consolidate data from monitoring and program auditing and produce compliance reports.This process has begun to produce Compliance Reports in some areas. RSSLC produces a monthly Allegations Trend Report, a monthly Unusual Incidents Trend Report, a monthly Injury Trends Report, and a monthly Restraint Trend Analysis. These reports contain most of the required elements required by the SA for the current report month. Only a limited data set is displayed for a rolling 12-month period limiting its utility in trend analysis. The other trend reports generated by the RSSLC similarly do not present rolling 12-month data which limits their usefulness in fully analyzing trends and targeting administrative and programmatic actions which may be needed to address particular issues, especially systemic issues, in particular locations, at particular times, or with particular staff and individuals. While the Facility had begun to demonstrate a capacity to generate corrective action plans responding to sentinel events, it had not as yet developed the capacity to develop and implement corrective action plans that address problems identified through the quality assurance process. To meet this requirement of the SA the Facility must be able to demonstrate its QA process is collecting sufficient data from which comprehensive analysis can produce the identification of underlying systemic causes of problems that can be addressed through facility-wide, or department-wide, improvement initiatives. The QA director presented the Monitoring Team with a set of monitoring tools that corresponded to many of the provisions of the Settlement Agreement. Each tool consisted of a set of checklist-type items and had an attached set of instructions for completing each item of the tool. These tools were designed to be used at all of the SSLCs, were generated by DADS central office, and were based upon a set of tools originally used by the Monitoring Teams and developed in 2009. Some tools were slightly modified by RSSLC and the facility had created a compliance database to record monitoring findings and assess progress over time. The database presented to the Monitoring Team, which was developed in collaboration with the El Paso SSLC, appeared to have all the features necessary to eventually produce meaningful reports from well-organized data.

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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.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. DADS Policy 003- Quality Enhancement was reviewed and it was consistent with the requirements of the Settlement Agreement (SA). The Monitoring Team did not find comparable language the draft RSSLC policies. The RSSLC QA Department has developed several draft documents to guide its work. RSSLC Policy A.27 Quality Assurance/Quality Improvement Council has the stated purpose of: "The purpose of the Quality Assurance/Quality Improvement Council is to review and oversee the facility's status in regard to: 1. Regulatory/Life Safety visits; 2. Annual Peer Audits; 3. Facility Support Performance Indicator internal controls audits; and 4. Settlement Agreement monitor visits" RSSLC Policy A.27 goes on to describe a series of administrative and review activities the QA/QI Council is responsible for. Membership of the Council consists primarily of executive level administrative and clinical staff. The Monitoring Team finds it unusual that a QA/QI Council policy does not articulate a mission that focuses on improving the quality of life for the Individuals living at RSSLC. The scope and depth of the membership would allow for this. The policy, as presently written, focuses the resources of the QA/QI Council members almost entirely on managerial oversight of various tasks to ensure they are getting done. The meeting observed by the Monitoring Team served to validate this observation. RSSLC leadership may wish to engage in a heightened level of accountability activity requiring supervisors and managers throughout the organization to be strictly accountable for the work tasks assigned, so the QA/QI Council can direct its energy to data review, analysis, and development of action plans that are directed towards systemic or underlying causes of problems. The Monitoring Team understands this is a new and evolving process for the RSSLC and is hopeful that as the process matures it can find ways to review all data derived from all the tasks that are being done with a focus on the ways in which these data can be used to identify systemic and underlying causes of problems. The QA/QI Council could then focus its energy and resources on resolving these problems and planning and tracking initiatives to improve lives of people served by the Facility. RSSLC Policy A.28 Quality Assurance Plan has the stated purpose of: "The policy establishes a planned, systematic, organization-wide approach to monitoring, analyzing,	Noncompliance

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		and continually improving the quality of care and services provided to individuals served at the RSSLC. RSSLC implements quality assurance processes consist with current, generally accepted professional standards of care that detect problems with the provision of protections, services and supports, and ensures appropriate corrective action is implemented and results improve services and supports." The Quality Assurance Plan Draft, still under development, is in a matrix format and when complete will display what is to be monitored, who does the monitoring, what monitoring tools are to be used, the frequency of monitoring, the sample size and type, how and who aggregates data and generates reports, who and how the data is analyzed, and who reviews the analysis of the data. All this would be done, presumably, to lead to the development of action plans that are directed towards systemic or underlying causes of problems. The QA Department has established three Engagement/Active Treatment Teams comprised of five mock survey trainers (a Program Auditor, an Active Treatment Manager, a Vocational Director, a Behavior Analyst, and a QMRP), three Program Monitors, the Director of Residential Services, and the Director of Quality Assurance.These teams are to coach/train staff in active treatment philosophy and activities unique to individuals. It is anticipated that this initiative will lead to improved engagement between staff and individuals living at the RSSLC. This process was put in place in recognition of deficient practices with respect to meaningful and ongoing engagement of individuals receiving services (continuous active treatment). This model may be worth replicating as the QA process identifies other areas of deficient practices. From its review the Monitoring Team was able to determine that QA systems are in place and are in various stages of development, refinement, and maturation, including the development of a data system that can consolidate data from monitoring and program auditing and produce compliance reports.This process has begun to produce Compliance Reports in some areas. RSSLC produces a monthly Allegations Trend Report, a monthly Unusual Incidents Trend Report, a monthly Injury Trends Report, and a monthly Restraint Trend Analysis. These reports contain most of the required elements required by the SA for the current report month. Only a limited data set is displayed for a rolling 12 month period limiting its utility in trend analysis. Most, if not all, data elements should include longitudinal tracking. Current month data on the Allegations Trend Report includes identification of type of	

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		allegation; staff involved, individuals involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigations. This provides a good snapshot of the current month; however, these data are not trended over time, such as a rolling 12 month period. The Monitoring Team believes they must be in order to achieve compliance with this provision of the SA. The other trend reports generated by the RSSLC are similarly deficient in presenting too brief a duration of data (for which arolling 12-month period would generally be appropriate and adequate), which limits their usefulness in fully analyzing trends and targeting administrative and programmatic actions which may be needed to address particular issues, especially systemic issues, in particular locations, at particular times, or with particular staff and individuals.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. DADS Policy 003- Quality Enhancement was reviewed and it was consistent with the requirements of the Settlement Agreement (SA). The Monitoring Team did not find comparable language the draft RSSLC policies. The RSSLC QA Department has developed several draft documents to guide its work. RSSLC Policy A.27 Quality Assurance/Quality Improvement Council has the stated purpose of: "The purpose of the Quality Assurance/Quality Improvement Council is to review and oversee the facility's status in regard to: 1. Regulatory/Life Safety visits; 2. Annual Peer Audits; 3. Facility Support Performance Indicator internal controls audits; and 4. Settlement Agreement monitor visits" By policy the QA/QI Council engages in a series of administrative and review activities to achieve its stated purpose. Membership of the Council consists primarily of executive level administrative and clinical staff. The meeting observed by the Monitoring Team during the week of the review, and a review of meeting minutes from prior meetings, suggests the QA/QI Council, and the administrative activity that supports it, is not yet at a point where trend data are complete and are presented for review and analysis. RSSLC had a draft Quality Assurance Plan whose stated purpose is to "establish a planned, systematic, organization-wide approach to monitoring, analyzing, and	Noncompliance

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		continually improving the quality of care and services provided to individuals served at the RSSLC". RSSLC also had a draft Quality Assurance Plan Draft, still under development, which is in a matrix format and when complete will display what is to be monitored, who does the monitoring, what monitoring tools are to be used, the frequency of monitoring, the sample size and type, how and who aggregates data and generates reports, who and how the data is analyzed, and who reviews the analysis of the data. All this would be done, presumably, to lead to the development of action plans that are directed towards systemic or underlying causes of problems. While the Facility had begun to demonstrate a capacity to generate corrective action plans responding to sentinel events it had not as yet developed the capacity to develop and implement corrective action plans that address problems identified through the quality assurance process. To meet this requirement of the SA the Facility must be able to demonstrate its QA process is collecting sufficient data from which comprehensive analysis can produce the identification of underlying systemic causes of problems that can be addressed through facility-wide, or department-wide, improvement initiatives. Per interview, it was determined that the RSSLC did not as yet have a fully organized and uniform system for the development, implementation, and tracking of corrective action plans. There are elements in place, such as the follow-up tracking the Incident Management Coordinator does with respect to investigations. Corrective Action Plans were developed differently in different departments and tracking mechanisms were different in different departments. A challenge facing the QA Department will be to bring all this work effort together into a uniform system with common reports, common tracking, and common follow-up mechanisms. The Data Analyst had developed, very recently, a data system to support this. There are still several improvements needed in the overall design of the monitoring system that will eventually produce the trend data used in formulating correction action plans. Data items on the monitoring tools have not been weighted so in preparing overall compliance reports the most critical data item counts the same as the most mundane. Additional steps need to be taken to ensure monitors/reviewers who do not have specific subject matter expertise have adequate training and support from someone with specific subject matter expertise. An inter-rater reliability process is in place at RSSLC. The QA Director highlighted for the Monitoring Team examples of where this process indicated differences in the findings of monitors that were within a department and external monitors. This process is relatively new and the monitoring team would expect these differences to stimulate thoughtful discussion that can lead to improved inter-rater reliability in the future but more importantly improved services and supports to the	

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		Individuals living at the RSSLC. The QA Department may want to consider a formal requirement that if the inter-rater reliability is not within a specified acceptable range, a defined review process with those conducting the monitoring is to occur. Finally, some of the indicators on a tool may be specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise. Nevertheless, the work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of a sound QA system.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. DADS Policy 003- Quality Enhancement was reviewed and it was consistent with the requirements of the Settlement Agreement (SA). The Monitoring Team did not find comparable language in the draft RSSLC policies. Per interview, it was determined that the RSSLC did not as yet have a fully organized and uniform system for the development, assignment and dissemination, implementation, and tracking of corrective action plans. There were elements in place, such as the follow-up tracking the Incident Management Coordinator does with respect to investigations. Corrective action plans were developed differently in different departments and tracking mechanisms were different in different departments. From this review the Monitoring Team is unable to validate that corrective action plans are disseminated to all entities responsible for their implementation. A challenge facing the QA Department will be to bring all this work effort together into a uniform system with common reports, common tracking, and common follow-up mechanisms. The Data Analyst had developed, very recently, a data system that will assist in achieving this.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. DADS Policy 003- Quality Enhancement was reviewed and it was consistent with the requirements of the Settlement Agreement (SA). The Monitoring Team did not find comparable language in the draft RSSLC policies. Per interview, it was determined that the RSSLC did not as yet have a fully organized and uniform system for the development, implementation, and tracking of corrective action plans. There were elements in place, such as the follow-up tracking the Incident	Noncompliance

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		Management Coordinator does with respect to investigations. Corrective Action Plans were developed differently in different departments and tracking mechanisms were different in different departments. There was not evidence to demonstrate that there was a process to follow through from establishment of a corrective action to documentation of completion of the action and to evaluation to ensure the action was effective. From this review the Monitoring Team is unable to validate that corrective action plans were implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified. A challenge facing the QA Department will be to bring all this work effort together into a uniform system with common reports, common tracking, and common follow-up mechanisms. The Data Analyst had developed, very recently, a data system to support this. While the Facility had begun to demonstrate a capacity to generate corrective action plans responsive to sentinel events, it had not as yet developed the capacity to develop and implement corrective action plans that address problems identified through the quality assurance process. To meet this requirement of the SA the Facility must be able to demonstrate its QA process is collecting sufficient data from which comprehensive analysis can produce the identification of underlying systemic causes of problems that can be addressed through facility-wide, or department-wide, improvement initiatives.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. DADS Policy 003- Quality Enhancement was reviewed and it was consistent with the requirements of the Settlement Agreement (SA). The Monitoring Team did not find comparable language in the draft RSSLC policies. Per interview, it was determined that the RSSLC did not as yet have a fully organized and uniform system for the development, implementation, and tracking of corrective action plans. There were elements in place, such as the follow-up tracking the Incident Management Coordinator does with respect to investigations. Corrective Action Plans were developed differently in different departments and tracking mechanisms were different in different departments. There was not evidence to demonstrate that there was a process to follow through from completion of a corrective action to evaluation to ensure the action was effective and revision of the action if necessary. From this review the Monitoring Team is unable to validate that corrective action plans were modified as necessary to ensure their effectiveness. A challenge facing the QA Department will be to bring all this work effort together into a uniform system with common reports, common tracking, and common follow-up mechanisms. The Data Analyst had developed, very	Noncompliance

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		recently, a data system to support this. While the Facility had begun to demonstrate a capacity to generate corrective action plans responded to sentinel events it had not as yet developed the capacity to develop and implement corrective action plans that address problems identified through the quality assurance process. To meet this requirement of the SA the Facility must be able to demonstrate its QA process is collecting sufficient data from which comprehensive analysis can produce the identification of underlying systemic causes of problems that can be addressed through facility-wide, or department-wide, improvement initiatives.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Continue efforts to develop the quality assurance plan and associate QA policies, ensuring that SA requirements and State policy requirements are clearly articulated in RSSLC policies.
2. Work on the creation of a uniform QA system that uses common definitions, common instructions, common reports, common tracking, and common follow-up mechanisms.
3. Expand the data reported in Trend Reports to display more longitudinal data.
4. Ensuresubject matter content experts work with monitors and program auditors to validate that RSSLC auditors/monitors using each tool have sufficient knowledge from which to assess data items on each tool.
5. Develop a system of "weighting" data items on monitoring tools, where appropriate.
6. Use monitoring data to proactively identify homes, day/vocational programs, and/or departments that require improvement, as well as identify systemic issues requiring attention.
7. Develop and refine the system of corrective action planning that builds on work already underway. Include in this a process to track corrective actions from identification of the issue through establishment of a corrective action plan (including dissemination and assignment of responsibility) to documentation of completion and evaluation of effectiveness (with revision if needed).
8. Continue developing and refining the data system in place to support this section of the SA.

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) 4/18/11 3. RSSLC Policy F.1 Scheduling Annual Personal Support Plan (PSP) Meetings 3/24/11 4. RSSLC Policy F.2 Scheduling Initial Personal Support Plan Meeting 11/18/10 5. RSSLC Policy F.3 Participating in Annual Personal Support Plan Meeting 9/23/10 6. RSSLC PolicyF.4 Support Plan Process (Integrated Protections, Services, Treatments, and Supports)12/30/10 7. RSSLC Policy F.5 Completing Personal Support Plan Meeting Documentation 12/14/10 8. RSSLC Policy F.6 Participating In/Documenting Addendum Meetings 6/1/07 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 3/9/11 11. RSSLC Policy F.17 Participating in PSP Monthly Reviews 7/15/09 12. RSSLC Policy F.18 Participating in Personal Focus Assessment Meetings 4/20/11 13. RSSLC Policy F.19 Active Treatment Program Training 3/15/11 14. Richmond State School Meeting Attendance Tracking February/March 2011 15. PSP Meeting Date Log (undated) 16. Program Implementation Data Sheets for Individuals #112, #128, #156, #174, #210, #361, #511, #531,#573, and #711 17. Assessment Tracking by Discipline Log 1/1/11 to 5/3/11 18. PSP Monitoring Log 9/1/10 to 5/2/11 19. PSP Discipline's Assessments Tracking Worksheet for Individuals #96, #137, #268, and #384 20. Bar graphs by month of assessments tracking by discipline 1/1/11-5/5/11 21. PSP Meeting Monitoring Tool (undated) 22. PSP Review/Coaching Form 12/09 for Individual #663 23. Records for Individuals #6, #16, #84, #149, #347, and #385 24. Rights Assessment for #641 25. PSPs for Individuals, #6, #16, #29, #30, #84, #96, #109, #134, #137, #149, #174, #175, #185, #199, #213, #274, #283, #316, #322, #347, # 363 ,#385, #440, #442, #471, #512, #513, #573, #641, #679, #771, #783, #784 26. Personal Focus Assessment (PFA) for Individuals # 17, #39, #52, #115, #169, #179, #176, #192, #212, #215, #259, #268, #301, #353, #363, #385, #412, #462, #471, #508, #558, #559, #561, #683, #685, #700, #712, #714, #719, #792 27. PSPAs for Individual #52 from two 5/2/11 meetings **Persons Interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance

	2. Shannon Seale, Director of Residential Services 3. Judy Miller, Settlement Agreement Coordinator 4. Carol Agu, QMRP Coordinator 5. Ten Direct Care Professionals 6. Four QMRPs **Meetings Attended/Observations:** 1. PFA for Individual #561 2. PSPA meetings for Individual #52 and #477, 3. Group meeting with four QMRP's and QMRP Coordinator 4. Medical Nutrition Therapy Meeting 5/2/11 5. Pneumonia Meeting 5/3/11 6. PSP for Individuals #200, #442, #477, #601 7. At Risk Team Meetings for Individuals #363 and #385 8. Human Rights Committee (HRC)Meeting
	Facility Self-Assessment: The Monitoring Team reviewed the RSSLC POI. RSSLC reported it was not in compliance with any of the provisions, or the components with each provision, of this section of the SA. The monitoring team concurs. The POI described a number of actions the Facility had taken since the previous site visit, including the development of new policies and processes related to the Personal Support Plan. DADS issued new policy direction on PSP development in July, 2010. The training curriculum accompanying this new policy is entitled "Supporting Visions" and was intended to reinforce that planning is to support the individuals' vision for the future for him/herself. RSSLC received training on the new policy beginning in August, 2010. The new PSP format, and process, was being implemented at RSSLC but with limited success specific to the requirements of this section of the SA.
	Summary of Monitor's Assessment: RSSLC indicated it was not in compliance with any of the components for these provisions and the Monitoring Team concurred. The Monitoring Team reviewed a sample of documents in order to be able to assess progress, if any, from the previous site visit 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 F1:**DADS had issued new policy direction on PSP development in July, 2010 andmany RSSLC policies had been revised, some very recently, in light of the new State policy on PSP planning. The training curriculum accompanying this new policy entitled "Supporting Visions" was intended to reinforce the concept that planning is intended to support the individual's vision for the future for him/herself. RSSLC received training on the new policy beginning in August, 2010. Overall, the new PSP format and processwas being implemented at RSSLC but with limited success specific to the requirements of this section of the SA. PSTs often failed to conduct comprehensive assessmentsof sufficient quality to reliably identify the individual's strengths, preferences and needs. The Monitoring Team found this to be a pervasive issue at the Facility that will need immediate and sustained attention to remediate. The PFA process was not being implemented in a manner that was either timely or meaningful

	to the individuals for whom the plan was being developed. **Provision F2:**PSPs did not consistently specify 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 and meet identified needs, nor did barriers to living in the most integrated setting always lead to goals, objectives, or service strategies. The continued lack of revision to inadequate data collection and presentation practices will continue to be a substantial impediment for RSSLC in making progress toward compliance with this portion of the Settlement Agreement. The Facility had implemented a quality assurance process that is intended to identify and remediate the most apparent problems observed during a PSP meeting. The Monitoring Team commends the Facility staff for this quality assurance activity. This report summarized the results of monitoring done primarily by QA staff.Carefully documenting follow-up quality improvement activities and then tracking them to ensure the improvements have taken hold could improve this process.

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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 reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. DADS had issued new policy direction on PSP development in July, 2010. The training curriculum accompanying this new policy is entitled "Supporting Visions" and was intended to reinforce that planning is to support the individuals' vision for the future for him/herself. RSSLC received training on the new policy beginning in August, 2010. The new PSP format, and process, was being implemented at RSSLC but with limited success specific to the requirements of this section of the SA. Many RSSLC policies have been revised, some very recently, in light of the new State policy on PSP planning including: Policy F.1 Scheduling Annual Personal Support Plan(PSP)Meetings (revised 3/24/11), Policy F.2 Scheduling Initial Personal Support Plan Meeting (revised 11/18/10), Policy F.3 Participating in Annual Personal Support Plan Meeting (revised 9/23/10), PolicyF.4 Support Plan Process-Integrated Protections, Services, Treatments, and Supports (revised 12/30/10), RSSLC Policy F.5 Completing Personal Support Plan Meeting Documentation (revised 12/14/10), RSSLC Policy F.12 Organizing and Maintaining Active Treatment Notebooks (revised 9/7/10), RSSLC Policy F.13 Implementing and Documenting Active Treatment Programs (revised 3/9/11), RSSLC Policy F.18 Participating in Personal Focus Assessment Meetings (revised 4/20/11), RSSLC Policy F.19 Active Treatment Program Training (revised 3/15/11).	Noncompliance
F1a	Be facilitated by one person from	The RSSLC reported in its POI it was not yet in compliance with this component of this	Noncompliance

	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.	provision of the SA. The Monitoring Team concurs. PSP meetings observed by the Monitoring Team were facilitated by one person, a QMRP, who would ordinarily try to stimulate interdisciplinary discussion. These attempts were sometimes misguided, or otherwise did not contribute to the type of interdisciplinary discussion, using assessment data, that led to effective plan outcomes. For example the Monitoring Team attended the PSP and At Risk Meetings for Individuals #442, #385, and #363. At each meeting the Facilitator failed to assertively lead the discussion to ensure active participation of each PST member. The Facilitator primarily read from a prepared script without much eye contact with the participants, particularly the individuals being reviewed. The Nurse Case Managers present at the meeting passively participated, reading from their prepared nursing assessments. The content of the nursing reports were brief and mostly limited to individuals' medications, treatments, and a list of their Health Maintenance Plans. There were no clinical descriptions of individuals' health status regarding the rationale for the medical/health problems that led to the establishment of the Health Maintenance Plans or the status of individuals' progress or lack of progress toward the achievement of individuals' goals and objectives set forth in the plans.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. The teams would generally be expected to becomprised of the individual and/or LAR or a family member who does not have guardianship, clinicians representing specific services, and direct care staff. The Monitoring Team was provided with a document labeled Richmond State School Meeting Attendance Tracking which tracked attendance at PSP meetings by month. The Monitoring Team reviewed the log for February and March, 2011. This report showed the RSSLC had 33 PSP meetings in February and 30 in March. Data reported in this document revealed significant issues with PSP attendees being those people who regularly and directly provide services and supports to the individual. For example: 36% of the PSP meetings in February did not include direct care professionals, and 23% of the PSP meetings in March did not include direct care professionals. The Monitoring Team also found that documentation of attendance did not necessarily indicate active participation. In at least two PSPs attended during the monitoring visit, for Individuals #442 and #601, the direct care professionals attended, but were unprepared for and/or minimally involved in the planning process. In the PSP for Individual #442, the direct care staff was asked what the individual liked to shop for. The reply was this was unknown because shopping was completed on a different shift. It was also noted for the PSP for Individual #601, held during afternoon, the direct care professional that attended the beginning of the meeting did not remain for the entire session, but traded off with another staff person at change of shift. This was contrary to	Noncompliance

		the practice the Facility reported it had undertaken to ensure the direct care professional attended throughout the entire meeting. Other examples of issues with the appropriate composition and participation of the PST included: • 57% of the PSP meetings in February did not include the LAR; 69% of the PSP meetings in March did not include the LAR. • 64% of the PSP meetings in February did not include a physician; 62% of the PSP meetings in March did not include a physician. • 93% of the PSP meetings in February did not include a speech therapist; 77% of the PSP meetings in March did not include a speech therapist. • None of the meetings in either month included a dietician. On the positive note attendance by a QMRP was 100% in both months. Attendance by a nurse was 100% in both months. Attendance by a psychologist was 86% in February and 100% in March. Attendance by a Social Worker was 86% in February and 92% in March. In order to comply with this component of the SA it is imperative properly constituted PSTs attend each PSP meeting to ensure assessments and planning for an individual is integrated and services and supports are developed that are consistent with the individual's vision for the future. In addition, the Facility had implemented the new Personal Focus Assessment (PFA) which was intended to ensure the PSP would be centered on the needs, preferences and personal goals of the individual. The PFA was therefore an essential part of the PSP process. This requires that the participants in the PFA be the individual as well as those people who have close relationships with the individual and those who have knowledge of important preferences, goals and events in the individual's life. The PFA, particularly as it is currently implemented, should not be seen as a singular vehicle for preparing an individual to participate in his or her own planning in a meaningful way and to envisioning his or her future. Although individuals typically attend the PFA and PSP meetings, their actual participation is often very limited. Individuals with intellectual disabilities will benefit from repeated and ongoing experiential activities in this area, as with many others, as opposed to once or twice a year. The PFA process had not yet improved the level of participation of individuals in their own planning. 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 Monitoring Team recommends that the Facility implement a formal curriculum for "planning my future" that is incorporated into the overall active treatment	

		program on an ongoing and regular basis. Information regarding person-centered training models that might assist QMRPs to better facilitate this process may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html. Such a planning process might include, for instance, many opportunities across the year for staff to assist each individual to create pictorial representations of the things that matter to them. Using photographs, drawings, pictures from magazines and books, for example, each individual could develop a poster portfolio of such things as "Important People in My Life," Things I Want to Do," Places I Want to Go," What My Ideal Home Looks Like," "Things I am Good At," etc. These posters could then be placed on the walls to begin the PFA meeting, making it much more meaningful to the individual, simply by having the visual cues. It would also provide a more meaningful way for the PST to explore the PFA areas with the individual. The portfolio could then be revised for the PSP meeting based on the PFA results. This would make the PSP a much more comprehensible and positive experience. As an example, the Monitoring Team attended a PFA for Individual #561. The process included asking the individual the PFA questions in a verbatim and often rote manner. The individual did not appear to understand many of the questions and provided little input. The QMRP did use a dry erase board to document some of the team discussion, but this was only really helpful to the staff, not the individual. If there had been a series of posters up with material the individual recognized, the team members could have referred to them to help the individual stay involved in the process. The individual's family and staff indicated during the meeting that the individual would begin to provide "yes" answers if he became tired or bored. As the meeting progressed, it became apparent that the individual was beginning to do this, and often laid his head upon the table. Toward the end of the meeting, however, the PST members began to talk about what they liked about the individual. The individual raised his head at that point, began to pay attention and smiled broadly. This should be taken as an indication that the meeting could be held in a manner that would better encourage the individual's participation.	
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.	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. RSSLC often failed to conduct comprehensive assessmentsof sufficient quality to reliably identify the individual's strengths, preferences and needs. The Monitoring Team found this to be a pervasive issue at the Facility that will need immediate and sustained attention to remediate. Assessments were not routinely being completed on a timely basis. The Monitoring Team was provided a document labeled "Assessment Tracking by Discipline 1/1/11 to 5/3/11." This document tracked whether or not assessment required of various disciplines were present at the time of an individual's PSP meeting. The Monitoring Team	Noncompliance

		sampled these data for Individuals #96, #137, #268, and #384 (selected non-randomly). For these individuals, a total of 58 assessments (by various disciplines) were identified as being required. This report shows that 21 (36%) assessments were not present and available for the individuals' PSP meetings, as reported in the table in Provision component F1(d). The Monitoring Team also reviewed a sample of these data by discipline. The first page of the report includes data for 15 individuals. In six (40%) instances the medical assessment was not present. In three (20%) instances the nursing assessment was not present. In six (40%) instances the psychological assessment was not present. This report included, for some assessment categories, an entry of N/A which the Monitoring Team accepted on its face. Through its own reporting data it is evident to the Monitoring Team that the RSSLC needs substantial improvement to ensure assessments are done timely. The Monitoring Team reviewed 29 PFAs for individuals who were scheduled to have PSPs the week of May 9-May 31, 2011. These assessments were intended to be done at the time of the third quarterly review per State policy, which would typically be approximately 90 days before the PSP meeting. They were then to be used by all disciplines to guide the development of their own assessments, incorporating the preferences and personal goals identified in the PFA. Of the 29 reviewed, only nine (31%) were completed during the month of February, which would be in the prescribed timeframe. The remainder were completed during March and April. The latest completion date was 4/28/11. In addition to issues of timeliness, RSSLC PSTs did not routinely conduct comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. Examples included: • Of the 29 PFAs reviewed, only eight (28%) indicated the individual had any specific goals or dreams for the future. In many instances, it was documented this was non-discernible or the individual was unable to state any goals or dreams. This represented a failure of the PSTs to recognize the PFA as a person-centered planning tool that was intended to assist the team and the individual to explore personal goals and dreams. It points out a need for training for Facility staff in procedures to identify preferences of individuals who do not use spoken language or otherwise have significant communication deficits. • As reported in Provision U1, the Facility did not have a process in place to assess an individual's need for guardianship. • As described in more detail under Provision U1, the PST did not always carefully assess the individual's response when completing the Rights Assessment. For example, Individual #641 gave an appropriate response to whether he wished to have his picture taken, yet the team concluded he was unable to provide consent	

		in this area. While there may have been additional information taken into account to support this determination, none was documented nor was the QMRP able to elaborate. • For two of two At Risk Meetings attended by the Monitoring Team, the PSTs did not demonstrate the ability to use the Integrated Risk Rating Form to thoughtfully consider the individuals' risk levels, resulting in the failure to adequately and correctly identify significant risk. For example, for Individual #363, the individual has demonstrated substantial and recent challenging behavior that puts her at risk. The PST placed her at medium risk in this area because the criteria on the Risk Assessment form did not fully capture the nature and extent of the behaviors. When questioned by the Monitoring Team, the PST was clearly aware this was an area of higher risk for the individual, but was not sufficiently proficient in using the risk assessment process in a thoughtful, interdisciplinary manner required to translate this knowledge to an accurately assessed need. • During the PSP for Individual #200, the PST discussed the Individual's chronic weight loss in relation to rumination. Several recommendations were offered, such as increasing the number of meals, walking, and distraction. At no point was it suggested that a comprehensive assessment of the rumination behavior should be conducted. A comprehensive behavior assessment would have helped the psychologist better understand the behavior, as well as the likely function and maintaining contingency of the behavior. Without such information, the probability of developing a successful intervention was substantially reduced. In addition, in a discussion of the falls experienced by the individual, it was reported that the individual fell fewer than once per month. The data actually reflected that the individual had fallen at an average frequency of greater than twice per month. When the mother inquired about a recent fall in the bathroom, the nurse could not find documentation of the event. • For Individuals #442, #385, # 363 and #134, a review of current PSPs indicated they consistently failed to include an adequate nursing assessment or action plan for the risk factors identified or the chronic conditions that should have been addressed. The same was true for active medical problems. • Members of PSTs were not consistently attending meetings in which their expertise was most needed. Lack of participation resulted in the individual not receiving a comprehensive review in response to a change in status. For example, Individual #385 was diagnosed with aspiration pneumonia on 11/3/10. There was no evidence of OT or SLP involvement in the PST meeting on 11/1/10 or 12/3/10. Issues were also identified in Physical Nutritional Management (PNM) planning. Based on a review of 15 individual records, documentation supported that the PNM Team or PST did not meet regularly to address change in status, indicators of increased risk,	

<table>
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<td>clinical data and monitoring results. Individual examples of where the PNM Team or PST did not meet regularly to address change in status, assessment, clinical data and monitoring results included:
• Individual #6 was diagnosed with aspiration pneumonia on 7/5/10. There was no PST or PNMT response to the incident.
• Individual #16 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 #84 was diagnosed with aspiration pneumonia on 5/21/10 and 1/6/11. 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 or PST met to discuss the issue.
• Individual #347 had a choking event on 11/14/10. There was no evidence of a comprehensive oral motor assessment to determine if there was a decline in swallow function.
• Individuals #149, #322, 512 had swallow studies completed but there was no evidence of PST or PNMT review of findings.</td>
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<tr>
<td>F1d</td>
<td>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.</td>
<td>The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs.

Assessments were due in the shared drive 10 days before the PSP to ensure that PST members were prepared to use the results to develop a PSP that outlines the protections, services, and supports to be provided to the individual. The Monitoring Team reviewed a sample of four individuals to evaluate compliance with this requirement and found that assessments were often not available for the PST members to review during the requisite time period, as shown below:

<table>
<tr><th>Individual #</th><th>Number of required assessments in share drive 10 days before PSP/not in timely</th><th>Number of assessments QMRP provided notice to UD</th><th># of assessments info was/was not obtained for PSP</th></tr>
<tr><td>#96</td><td>10/5 (67%)</td><td>5 (100%)</td><td>2/3 (40%)</td></tr>
<tr><td>#137</td><td>11/4 (73%)</td><td>4 (100%)</td><td>2/2 (50%)</td></tr>
<tr><td>#268</td><td>8/6 (57%)</td><td>No information</td><td>No information</td></tr>
<tr><td>#384</td><td>4/10 (40%)</td><td>10 (100%)</td><td>No information</td></tr>
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RSSLC often failed to use assessment results to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. Examples included:
• For Individual #641, the PST completed the Rights Assessment and indicated a</td>
<td>Noncompliance</td>
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		rights restriction was needed in money management because the individual would give money away, but the strategies the PST developed intended to address the restriction focused on teaching the individual how to discover the amount in the individual's fund and did not address this tendency to relinquish money to others. • Individual #442 used a walker, but remained at increased risk for falls because he liked to carry many items in his hands. The individual received balance and strength training three times per week. Habilitation staff had also provided him with a bag carrier for his walker, but he was reluctant to use it. The PST spent a considerable amount of time discussing this at the PSP meeting, and even looked at the walker and bag and strategized how he might be encouraged to use the bag. Neither the ongoing balance and strength training or the strategies for safer use of the walker were included in the PSP. • For Individual #252, a PSP was held on 5/4/11 and Community Living Discharge Plan (CLDP) was to be held on 5/06/11. As described in more detail in T1c1 below, the individual had experienced rectal bleeding beginning in December 2010 and had an ultrasound on 4/15/11 that revealed a possible mass. No additional follow-up had yet been scheduled. The QMRP reported that the PST had agreed at the PSP meeting that this could wait for follow-up until after the individual moved to his new community home, which would be a minimum of two to three weeks following the CLDP. This would mean a delay in diagnosis of many months, which would not be consistent with standards of care. Once this was brought to the attention of the Facility by the Monitoring Team, a follow-up was scheduled. .	
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).	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. 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 one of two PSPs observed during the monitoring visit (50%), and for 11 of 14 PSPs reviewed (79%), the PST failed to adequately consider and provide an assessment, by qualified professionals, of the most integrated setting appropriate for the person. The PSTs continued to largely defer 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 #442, the PST concluded during the PSP meeting that the most appropriate living option for the individual was RSSLC, although there was no significant information presented that appeared to preclude community living	Noncompliance

		other than the expressed preferences of the family, LAR, and individual for continued residence at the Facility. Following the meeting, the Monitoring Team questioned the PST as to their professional assessment of the most integrated setting for the individual. The unanimous response of the team was that community living would be the most integrated setting. The PST indicated it did not understand it was supposed to identify the most integrated setting from its professional perspective if the LAR or family was opposed. Once this was clarified, the PST noted in the final PSP document that it felt the individual could be served on the community with appropriate supports. It then went onto say the individual and the guardian wanted the individual to remain at RSSLC and that the "PST therefore agreed with (the) guardian that the most integrated setting for (the individual) at this time is his current home…" • The Monitoring Team interviewed four QMRPs and the QMRP Coordinator and asked about their understanding of the PSTs' responsibility to identify the most integrated setting appropriate to an individual's needs. All indicated some understanding of this responsibility and one stated that her PST always completed and documented this assessment in the PSP. The Monitoring Team reviewed 14 recent PSPs completed between 2/11 and 5/11 to evaluate this component. For 11 of the 14(79%), the Monitoring Team found the PST did not make an independent professional assessment of the most integrated setting appropriate to the individuals' needs. Please refer to Provision T1b for additional detail.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:	The RSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. DADS issued new policy direction on PSP development in July, 2010. The training curriculum accompanying this new policy is entitled "Supporting Visions" and was intended to reinforce that planning is to support the individuals' vision for the future for him/herself. RSSLC received training on the new policy beginning in August, 2010. The new PSP format, and process, was being implemented at RSSLC but with limited success specific to the requirements of this section of the SA. Many RSSLC policies have been revised, some very recently, in light of the new State policy on PSP planning including: Policy F.1 Scheduling Annual Personal Support	Noncompliance

		Plan(PSP)Meetings (revised 3/24/11), Policy F.2 Scheduling Initial Personal Support Plan Meeting (revised 11/18/10), Policy F.3 Participating in Annual Personal Support Plan Meeting (revised 9/23/10), PolicyF.4 Support Plan Process-Integrated Protections, Services, Treatments, and Supports (revised 12/30/10), RSSLC Policy F.5 Completing Personal Support Plan Meeting Documentation (revised 12/14/10), RSSLC Policy F.12 Organizing and Maintaining Active Treatment Notebooks (revised 9/7/10), RSSLC Policy F.13 Implementing and Documenting Active Treatment Programs (revised 3/9/11), RSSLC Policy F.18 Participating in Personal Focus Assessment Meetings (revised 4/20/11), RSSLC Policy F.19 Active Treatment Program Training (revised 3/15/11).	
	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 RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. The Facility was implementing the new PSP process, which called for a Personal Focus Assessment (PFA) to be completed at the time of the third quarterly review to assist the PST to prepare for the annual meeting.As discussed throughout this Section F, particularly in F1b, the PSTs had not been consistently completing the PFA in such a manner that they could not be said to have a full understanding of the individual's preferences and strengths. Thus, it is not feasible that a plan developed without this understanding could address the individual's needs in a manner that built upon those preferences and strengths.	Noncompliance
	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;	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. PSPs did not consistently specify 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 and meet identified needs. PSPs reviewed contained Action Plans but most did not contain complete or specific information. Examples included: • As described above in 1d, Individual #641 had a rights restriction in money management because he would give his money away, but that the strategies the PST developed intended to address the restriction focused on teaching the individual how to discover the amount in the individual's fund and did not address his tendency to relinquish his money to others. • For Individual #442, Action Plans included non-specific statements such as "...will indicate to staff where trust fund money comes from," "will respect other people's personal space," "will avoid inappropriate behaviors and "will perform basic self-care skills." Barriers to living in the most integrated setting did not always lead to goals, objectives, or	Noncompliance

		service strategies. • For Individual #442, the PST identified the guardian's preference that the individual remain at RSSLC as an obstacle to the Optimistic Living Vision of a community setting. The PST did not develop any individualized, observable and/or measurable goals/objectives or any treatments or strategies to be employed to address this obstacle. • For Individual # 274, the PSP dated 8/18/10 included an Action Plan that said the individual would have opportunities to visit group homes on a quarterly basis. The Monitoring Team requested documentation of these visits, which should have also included information provided to the PST regarding the individual's reaction to the visits and the PST deliberations in response. The only documentation provided was an attendance sheet for a single community group home tour that included 35 additional individuals.The Facility provided no documentation of PST consideration of the individual's response to the visit nor of any revision of the PSP or plan to implement the Action Plan.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. The Facility PSPs often failed to integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. Examples included: • For Individual #442, the PST identified a number of needs for services and supports, but failed to integrate all services and supports and other interventions provided for the individual. For example, according to the PFA, Individual #442 enjoyed recreational trips and weekly shopping trips. It further stated money was important to him. The PST discussed that the individual did not appear to understand where money comes from. It was further noted that the individual had mastered all the tasks involved in the contract work at the RSSLC workshop, but often did not stay on task, preferring to read magazines and smoke his pipe. None of this information was documented in the completed PSP. The only money management objective developed was for the individual to "indicate to staff where trust fund money comes from" when provided with verbal prompts. There was no indication in the PSP how money management skills might be integrated with his shopping and recreational preferences in the community, nor with his lack of attending skills at work. • In the area of health care, Individual #134's PSP, 4/14/11, Action Plan #4 to Maintain Health failed to include any plans for managing the medical/nursing problems. Rather, the plans specific to medical/nursing actions only included instructions for the nurse to train Individual #134 on the Self Administration of Medication. If the purpose of Individual #135's PSP was to integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual, as required in this provision's F2.3, then, Individual #134's PSP was grossly inadequate to meet his medical/health	Noncompliance

		care needs. Refer to Provisions M1 and M2. • PSPs contained references 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. The PSPs offered very limited descriptions of how an individual communicated with others**.** In most cases only recommendations from the communication assessment were identified in the plan rather than descriptions of the individual's abilities or potential. Strategies that staff could use to communicate were also very limited or non-existent. An example of this was Individual #783's PSP that stated gestures are used but provided no information regarding strategies to improve interaction or the catalog of gestures. 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;	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. Examples can be found in several sections of this Report. Examples include: • Lack of time frames,to allow for the determination that the intervention was not successful and in need of revision, as noted in Provision K3. • As reported in Provision M3, Acute Care Plans and Health Maintenance Plans failed to specify who would implement the interventions, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. • As reported in Provision O3, Physical and Nutritional Management plans failed to specify who would implement the interventions, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. For Individual #442, the PST identified a number of needs for services and supports, but failed to effectively address the individual's needs for services and supports that would be practical and functional at the Facility and in community settings. For example: • As reported in F2a3, Individual #442 enjoyed recreational trips and weekly shopping trips and money was important to him. The PST discussed that the individual did not appear to understand where money comes from. It was further noted that the individual had mastered all the tasks involved in the contract work at the RSSLC workshop, but often did not stay on task, preferring	Noncompliance

		to read magazines and smoke his pipe. None of this information was documented in the completed PSP. The only money management objective developed was for the individual to "indicate to staff where trust fund money comes from" when provided with verbal prompts. There was no indication in the PSP how money management skills might be integrated with his shopping and recreational preferences in the community, nor with his lack of attending skills at work. • There was no Action Plan developed to address his lack of attending skills or participation at work, even though this would also impact his ability to earn money. • Because attending to work tasks and earning money might be essential to successful living in a preferred setting (depending on the individual's choice of setting and provider), the Facility should identify a practical approach to developing and maintaining awareness by the individual of the relationship between working, earning money, and purchasing preferred items. Additional examples of the failure to provide 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 included: • As reported in Provision U2, Individual #641 had a rights restriction in money management because he would give his money away, but the strategies the PST developed intended to address the restriction focused instead on teaching the individual how to discover the amount in the individual's trust fund rather than developing practical means to assist the individual to keep and use money. • 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. The PSPs offered very limited descriptions of how an individual communicated with others**.** In most cases only recommendations from the communication assessment were identified in the plan rather than descriptions of the individual's abilities or potential. Strategies that staff could use to communicate were also very limited or non-existent. An example of this was Individual #783's PSP stated gestures are used but provided no information regarding strategies to improve interaction or the catalog of gestures.	
	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	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. During the current site visit, it was obvious that RSSLC had implemented minimal changes to the data collection process. Observations and record reviews reflected the lack of change in data collection practices.	Noncompliance

	individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	The following chart reports information on use of data collection methods and documentation of interobserver agreement in PBSPs. The data system needs to be more sensitive to each individual's needs. That is, in addition to providing an efficient means for the DCPs to collect data, the data system needs to be able to assess both behaviors that occur at low rates, as well as behaviors that occur at very high rates (e.g., stereotypic behavior, undesirable verbal behavior, etc.) with accuracy. 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 recommended that the Facility expand its data collection system to allow it to assess the occurrence of all target and replacement behaviors accurately. Similarly, lack of clear identification and use of objective and reliable data identified in the PSP was found in other areas of treatment. For example, as reported in Provision M3, Nurse Case Managers completing the nursing summary section were making a concerted effort to analyze and summarize the clinical data, but little progress was made in spite of the increased amount of data included in the summaries. The summaries contained statements from the nursing notes, sick call notes, results of labs and diagnostic tests, lists of medications and treatments received throughout the quarter. Many summaries contained statements such as the individual "has been in fair health this quarter," "had been medically stable this quarter," and "has enjoyed the best of health this quarter." These statements were subjective and did not describe the individuals' actual health status and should be avoided. 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 18 of 18 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 18 of 18 records (100%), treatment objectives were stated in terms of total frequency while data were presented as daily mean frequency per week. • In 18 of 18 records (100%), progress notes and other data reports presented	

	10/2010	5/2011	Change
Data collection utilized methods other than the DRA Sheets to document behavior displays.	0%	0%	0%
Documentation of attempts to collect inter-observer agreement on treatment data.	0%	0%	0%

		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 #618 included three data graphs with three different Y-axis maximum values (.04, .14, and .40). 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 three of 18 records (17%), the maximum value of the Y-axis changed from one month to the next. This can lead to misinterpretation when comparing data month to month. • In 18 of 18 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. In seven of 18 records (39%), the graph legend covered a substantial portion of the data points and data path on the graph. By blocking the data points from view, the ability to determine intervention response was substantially impaired.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. As documented in examples found in several sections of this Report, there is a lack of coordination in the PSPs among the goals, objectives, anticipated outcomes, services, supports, and treatments. For example, there were few examples in which more than one goal was developed to provide an integrated approach to meeting a desired outcome.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. The random sample of ten Direct Care Professionals interviewed by the Monitoring Team 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.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs.	Noncompliance

	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.	As an example, due to the issues related to data collection procedures as described in F2a6 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. As a result, evidence-based decisions regarding treatment were not routinely formed or even possible. This may have contributed to the lack of action to revise programs documented in the following examples: • For Individual#112, displays of aggression had been increasing over 4 months while other undesired behaviors declined. The progress review did not indicate whether this intervention was considered successful or in need of revision. • For Individual #156, aggression and other undesired behaviors increased over six months while no strengthening of replacement behavior was documented. For each of the six months, progress notes contained the recommendation to continue the PBSP. • For Individual #174, data on self-injury had not indicated a consistent response to treatment over the previous 12 months. A safety plan was implemented in September of 2010, but documentation did not reflect any changes to the PBSP. • For Individual #531, successful displays of replacement behavior had decreased for six months as self-injury was increasing. Documentation did not reflect a review of the behavior assessment or intervention strategy. Another example is reported in Section P. For individuals receiving direct Occupational and Physical Therapy direct therapy, daily progress notes were not consistently written nor were monthly summaries clearly identifying the degree of progress obtained from treatment. The continued lack of revision to inadequate data collection and presentation practices will continue to be a substantial impediment for RSSLC in making progress toward compliance with this portion of the Settlement Agreement.	
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	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. The Facility had provided initial 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 September, 2010. This training is primarily an orientation to a different way of planning for the lives of the Individuals living at the RSSLC. In its POI the RSSLC reported training is competency based but many staff had not as yet been trained using the competency based version of PSP training. Based on the monitoring data presented to the Monitoring Team and the evidence throughout this Section F, the training appears to have, as yet, limited effect on positive practices at the	Noncompliance

	with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	RSSLC. The Monitoring Team interviewed four QMRPs and the QMRP Coordinator. The QMRPs indicated the training they received in order to implement the PFA process was very short and not sufficient. They further stated they did not believe the PFA process could be successful unless other PST members received specific and interdisciplinary training on the PFA, which had not yet occurred. The QMRP Coordinator said the plan would be to provide this training to other PST members once all QMRPs had received Facilitator training. The QMRPs had a number of other recommendations regarding the PFA process. In some instances, the Monitoring Team concurred with these recommendations, particularly that the PFA should take place outside of the conference room, in a locale more conducive to a person-centered planning meeting. Other recommendations included shortening the timeframe for initiating the PFA from the current three months and decreasing the redundancy of the questions on the PFA. The Monitoring Team observed that these concerns were related to the lack of training, and therefore understanding, about the PFA process. QMRPs and PSTs did not demonstrate an understanding of how to use the PFA as a tool to stimulate and guide the discussion during the meeting, nor to guide the overall annual assessment process. It is recommended that DADS and the Facility evaluate the implementation of the PFA process thus far to assess what steps are needed to remediate the many issues associated with it. As described in section F.2.g, the Facility continued to evaluate the performance of the PSTs during PSP meetings.	
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 RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. PSPs were not always completed within 12 months of the previous PSP. The Monitoring Team reviewed a tracking log provided by the Facility of PSP dates for 350 individuals. For example, Individual #155 had a PSP meeting on 8/24/10. The individual's previous PSP was on 8/18/09. Individual #404 had a PSP meeting on 6/14/10. The individual's previous PSP was on 6/10/09. This tracking log included Individuals admitted to the Facility within the last 12 months.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance	The RSSLC reported in its POI it was not yet in compliance with this component of this provision of the SA. The Monitoring Team concurs. The Facility had implemented a quality assurance process that is intended to identify and remediate the most apparent problems observed during a PSP meeting. As this process	Noncompliance

	processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	matures it is expected that PSP development in the future will become more compliant with the requirements of this section of the SA. A Personal Support Plan Monitoring summary report was provided to the Monitoring Team. This monitoring done by the RSSLC indicates substantial improvement in the PSP process is needed at the RSSLC. The report summarized the results of monitoring done primarily by QA staff. The staff person assigned to monitor an individual's PSP process records data. For example, the QA Coordinator monitored the PSP process for Individual #424. Data collected addresses pre-meeting requirements, observation of the PSP meeting, a special focus on the rights assessment for the individual, and assessment of action plans directed to be developed by the PST. Each category assesses multiple compliance probes by the monitor. These data are included in the summary report referenced above. This report summarized data for 33 Individuals who had their PSP meeting monitored between 9/1/10 and 5/2/11. The report shows a compliance percentage of 59% for pre-meeting activities probes, 62% for the PSP meeting (which includes observation by the monitor of interdisciplinary discussion that leads to multi-disciplinary integrated planning), 59% for rights assessment probes, and 41% for probes associated with action plans. The report also synthesizes these data to provide an overall compliance rating which represents the average level of compliance for each individual. This is reported as 55%. The Monitoring Team commends the Facility staff for improvements in itsquality assurance activity. This processneeds to continue to improve, including: 1) developing remediation strategies that demonstrate increased compliance over time, 2) tracking QA data in sufficient organizational detail to identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section, and 3) expanding QA activity to include things like the timeliness of assessments described earlier in this report.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Continue training staff on the Supporting Visions PSP process
2. DADS and the Facility evaluate the implementation of the PFA process thus far to assess what steps are needed to remediate the many issues associated with it.
3. Implement a formal curriculum for "planning my future" that is incorporated into the overall active treatment program on an ongoing and regular basis. Information regarding person-centered training models that might assist QMRPs to better facilitate this process may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html.
4. 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.
5. Establish mechanisms that are intended to foster greater interdisciplinary integration in assessments and program planning.Additional training

should be provided on how to the develop integrated action plans that draw together the information gathered inassessments, how to analyze that information and incorporate the individual's preferences, and how the priorities can be translated into cleardirections for those working with the individual.

6. Improve efforts to ensure assessment are timely, and of sufficient quality, to be useful in the PSP planning process.
7. Improve efforts to ensure direct care professionals, guardians, and LARs attend and participate in PFAs and PSPs.

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) 4/18/11 2. RSSLC Settlement Agreement Status Update May 2011 3. DADS Draft Policy 005 Minimum & Integrated Clinical Services dated 01/12/2010 4. Medical records including consultation and Modified Barium Swallow Study (MBSS) reports for Individuals #149, #322, #512, #573, and #784 5. Local Chronic Clinical Indicator policy, draft, undated 6. Completed Chronic Clinical Indicators for diabetes, hypertension, hyperlipidemia, and osteoporosis 7. Draft local policy for "Acute Clinical Indicators", undated 8. Blank copy of "Acute Clinical Indicator" form. 9. PSPs and other documents reviewed by all members of the Monitoring Team **People Interviewed:** 1. Tran Quan, M.D., Medical Director 2. Interviews with other discipline staff by the members of the Monitoring Team, as identified in other sections of this report. **Meetings Attended/Observations:** 1. Weekly Psychiatric Clinic led by Dr. Ohiku 2. Integrated Morning Meeting 5/4/11 3. PSP Meeting for Individual #96 5/4/11
	Facility Self-Assessment: The Facility reported that it was not in compliance with either provision of this section. The Facility reported taking a number of important actions toward compliance. For Provision G1, the Facility reported actions including: • The psychiatrist and Primary Care Provider (PCP) attend the neurology clinic with the individual. • A multidisciplinary weekly meeting was implemented to have a collaborative discussion on individuals who had changes in status or recent hospitalizations or who present complex issues. • A multidisciplinary committee was established to reduce cases of pneumonia. For Provision G2, the Facility reported that policies for consultations were revised and a new consultation form was established to document acceptance or decline by the PCP of a non-Facility consultant's recommendation.

	The Monitoring Team concurs that the Facility is not in compliance with either provision of this section but that the above actions had been implemented and improved integration of clinical services.
	Summary of Monitor's Assessment: Actions taken by the Facility demonstrate both the positive finding of a commitment to moving toward integrated planning and also that further practice will be needed for evolution from multidisciplinary to joint and integrated case formulation and treatment. These included training staff in the new PSP process, initiation of an Integrated Morning Meeting to discuss specific cases, and establishment of a weekly psychiatric clinic with interdisciplinary involvement. An overall facility plan was not in place to address integrated clinical services, although a number of activities were occurring (see below). A facility policy did not exist; however, a draftDADS statewide policy was available. This state policy was not yet complete. The new PSP process is intended to promote integrated planning, Although progress had been made in development of interdisciplinary participation in a number of areas and the PSP planning meeting no longer involved reading of reports and recommendations, the process remained multidisciplinary in the sense that much decision-making still was done by disciplines rather than through thorough PST discussion. There was still a lack of participation by some disciplines, including direct care professionals, physicians, and speech therapists. Attendance by psychiatrists is limited due to staffing issues, but the lead psychiatrist attempted to attend as many PSP meetings as possible. Nevertheless, the actions and initiatives described below demonstrate movement toward compliance: The Integrated Morning Meeting consists of all clinicians, psychiatrist, clinical pharmacist, habilitation coordinator, nurse case managers, QMRPs, behavior analyst, unit directors and direct care staff, and meets every Wednesday to discuss a predetermined case, which is based on changes in functional status of an individual, or if there was recent and challenging hospitalization of an individual. An additional way in which the Facility had begun to integrate medication treatments with behavioral and other interventions was the PBMC clinic. Each individual was reviewed every three months, and many individuals were reviewed monthly. The clinical pharmacologist and senior behavior analyst, by the individual's behavior analyst, nurse case manager, social worker, QMRP, and direct care professionals, attended PBMC reviews. Although this collaborative effort was intended to and did provide opportunity for integrated planning, and there was input and information from the various disciplines, this did not result in joint case formulation that unified understanding of the individuals or in integration of treatments and interventions. This was a good beginning to a process that needs to evolve from a multidisciplinary to an interdisciplinary process. There were improvements in integrated planning for wound care. The Wound Care Nurse continued to chair monthly, and when needed, Skin Integrity Committee Meetings. The Committee serves as an integrated forum to review all types of skin integrity issues.

	The Facility had implemented an integrated medication variance committee that involved several relevant disciplines. The Monitoring Team concurs with the assessment by the Facility that it had taken very positive steps. The Monitoring Team found substantial compliance for Provision G2.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility reported it did not comply but had implemented several actions to establish compliance with this provision. The Monitoring Team concurs in this. An overall facility plan was not in place to address integrated clinical services, although a number of activities were occurring (see below). A facility policy did not exist; however, a draftDADS statewide policy was available. This state policy was not yet complete. It addressed both integrated clinical services (section G) and minimum common elements of clinical services (section H). The aspects of the policy that addressed section G were minimal and will not likely be helpful to the Facility because the policy merely mimicked the wording of the Settlement Agreement without providing any direction to the Facility, such as specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring. Staff were trained in the new PSP process, which promotes interdisciplinary discussion during planning meetings. However, although progress had been made in development of interdisciplinary participation in a number of areas and the PSP planning meeting no longer involved reading of reports and recommendations, the process remained multidisciplinary in the sense that much decision-making still was done by disciplines rather than through thorough PST discussion. Furthermore, there is still a lack of participation by some disciplines, as reported in Provision F1b, including direct care professionals, physicians, and speech therapists. Attendance by psychiatrists is limited due to staffing issues, but the lead psychiatrist attempted to attend as many PSP meetings as possible. Due to staffing issues, SLPs and Dietitians did not consistently attend meetings in which their expertise was required. For example, Individual #385 was diagnosed with aspiration pneumonia on 11/3/10. There was no evidence of OT or SLP involvement in the PST meeting on 11/1/10 or 12/3/10. A valuable new process was developed to promote integrated discussion of concerns and services for specific individuals. The Medical Director initiated an "Integrated Morning	Noncompliance

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		Meeting." The meeting consists of all clinicians, psychiatrist, clinical pharmacist, habilitation coordinator, nurse case managers, QMRPs, behavior analyst, unit directors and direct care staff, and meets every Wednesday to discuss a predetermined case, which is based on changes in functional status of an individual, or if there was recent and challenging hospitalization of an individual. The Monitoring Team noted that this meeting functions similarly to a morbidity committee meeting and compliments the Medical Director and participants of this process. The Monitoring Team recommended that a formal policy be developed that clearly delineates the function of the meeting and responsibilities of each member. It is essential that all assignments that are derived from the meeting are track for completeness and efficacy. The Monitoring Team attended the meeting and observed that clear objectives and assignments must be made for each outstanding issue that was addressed. Comprehensive minutes should be prepared that outline each issues, objective and assignment. Another action that may increase integrated planning was the establishment of a weekly psychiatric clinic with interdisciplinary involvement. The Monitoring Team attended Dr. Ohiku's weekly clinic, which lasted about four hours. Individuals #9, #17, #77, #199, #346, #404, and #613 were seen during the clinic. The psychiatrist, clinical pharmacist and senior behavior analyst attended the entire clinic. Each clinical appointment was attended by the individual who was reviewed, and by that individual's nurse case manager, behavior analyst, social work and/or QMRP, and direct care professionals. Each appointment lasted about 30 minutes. Before the PBMC, behavior analysts had prepared consultation reports for each individual that provided summary information about the individual, for the period of time since that individual's previous PBMC appointment. During the PBMC the psychiatrist completed a form that was developed by Dr. Ohiku and Ms. Shelly Evan, Associate Psychologist V. The form included entries for the psychotropic medications, psychiatric diagnoses, symptoms /behavioral characteristic that related to the each medication, social functioning, occupational functioning, diagnostic assessment, polypharmacy details, medication response and general indications for further care. The general format for each appointment was that the psychiatrist examined/interviewed the individual. The clinical pharmacist reviewed laboratory data and informed the group about pharmacological issues such as drug interactions and drug metabolism. The behavior analyst presented data on target behaviors, and the nurse provided general health and side effect information. The assembled team discussed data from the PBSP, labs, DISCUS and Moses scores, and data on target behaviors, and general discussion followed. In addition, psychiatry and psychology participated in facility wide polypharmacy reviews. An additional way in which the Facility had begun to integrate medication treatments	

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		with behavioral and other interventions was the PBMC clinic. Each individual was reviewed every three months, and many individuals were reviewed monthly. The clinical pharmacologist and senior behavior analyst, by the individual's behavior analyst, nurse case manager, social worker, QMRP, and direct care professionals, attended PBMC reviews. Although this collaborative effort was intended to and did provide opportunity for integrated planning, and there was input and information from the various disciplines, this did not result in joint case formulation that unified understanding of the individuals or in integration of treatments and interventions. This was a good beginning to a process that needs to evolve from a multidisciplinary to an interdisciplinary process. There were improvements in integrated planning for wound care. The Wound Care Nurse continued to chair monthly, and when needed, Skin Integrity Committee Meetings. The Committee serves as an integrated forum to review all types of skin integrity issues. The membership consisted of Quality Assurance Nurses, Nutritionist, Medical Director, Unit Physicians, Infection Control Nurse, Habitation, Unit Director, Pharmacist, Unit Director, Nurse Managers, Nurse Case Managers, and other relevant discipline staff. The Nurse Case Managers present any individual who has diagnosed skin integrity issues. The Skin Integrity Committee Meeting Minutes documented discussion of problems that contributed to skin integrity issues and made recommendations for solving problems. The Facility had developed a medication variance committee, chaired by the Director of Pharmacy. The medication variance committee had met every month for the past three months. Membership consisted of pharmacy, nursing, physician, dental, and psychiatry staff. The Committee reviewed trends for medication variances from all disciplines (pharmacy, dental, physician and nursing services). Remedial action was to be provided by the specific department head. These actions demonstrate both the positive finding of a commitment to moving toward integrated planning and also that further practice will be needed for evolution from multidisciplinary to joint and integrated case formulation and treatment. The Facility had taken very positive steps but is not yet in compliance with this provision.	
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	The Medical Director, Dr. Quan, reported that the Facility revised the On-Campus Consultation and Off-Campus Consultation policies to include giving consult and PCP Recommendation forms to the QMRP and Nurse Case Manager. She stated that nurses report this is occurring. The Monitoring Team reviewed medical consultations and MBSS reports.Six of six consultations reviewed (100%) documented review by the facility clinician. Of those, four documented acceptance of recommendations, one documented rejection and	Substantial Compliance

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	recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	included a rationale or alternative plan, and one was referred to the PST resulting in an alternative plan.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should establish in the PSP mentoring process measures of integrated planning and use those to provide feedback and coaching.
2. The Facility should identify ways to use the Integrated Morning Meeting and psychiatry clinics to develop integrated case formulations and treatment recommendations and to develop documentation that clearly demonstrates this integration in PSPs and the active record.

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) 4/18/11 2. RSSLC Settlement Agreement Status Update May 2011 3. DADS Draft Policy 005 Minimum & Integrated Clinical Services dated 01/12/2010 4. RSSLC Policy I.00a Medical Services 1/21/11 5. PSPs, CLDPs, and other documents reviewed by members of the Monitoring Team, as identified in other sections of this report. 6. Records reviewed as identified in Sections J, K, L, M, O, P, Q, and R **People Interviewed:** 1. Interviews with various discipline staff by the members of the Monitoring Team, as identified in other sections of this report. **Meetings Attended/Observations:** 1. PSP Meeting for Individual #96
	Facility Self-Assessment: The Facility reported that it did not comply with any provision of this section but had initiated actions toward compliance, including the ones listed below. The Facility initiated a weekly multidisciplinary meeting (identified below as the Integrated Morning Meeting) to assess status changes, complex medical/psychiatric/behavioral cases, and recent hospitalizations. Policies for tracking clinical indicators were drafted, and indicators were divided into acute and chronic clinical indicators. A form was drafted to measure acute clinical indicators. State Office established a procedure for medical chart audit by a non-facility auditor; the first such audit at RSSLC occurred 3/22/11. One purpose is to ensure treatment and interventions are timely and clinically appropriate. The Monitoring Team concurs that no provision of this section is yet in compliance and also that the actions taken are appropriate and should move the Facility toward compliance with this section.
	Summary of Monitor's Assessment: The Facility had made progress on several requirements of this section but did not comply with any provision. The Facility had taken actions that should improve the review of clinical indicators and the use of indicators to trigger assessments and revisions in treatments and interventions. Although these have not yet led to compliance with provisions of this section, and additional actions will be needed, they should

	continue. These actions include: • The Integrated Morning Meeting • The development and expansion of the Acute Clinical Indicator process • The Skin Integrity Committee Provision of assessments on both a regular basis and in response to developments or changes in an individual's status was not consistent across all disciplines. Regular assessments were not consistently done as scheduled. Assessments also did not always occur in response to change in an individual's health status. Although most diagnoses were consistent with the conditions listed in the DSM and ICD codes, some were not. Interventions were not always revised when progress was not occurring or when changes in status occurred. The Facility had begun development of determination of clinical indicators. A good example was the development and implementation of an "Acute Clinical Indicator" process. The process was intended to provide Clinical staff with greater insight in the management of acute medical conditions at the Facility. The Medical Director continues to develop the process and reported to the Monitoring Team that the Facility will implement a pilot program by the time of the next review. However, the availability, use, and documentation of clinical indicators continued to need improvement. The Aspiration Trigger Data Sheet was implemented for all individuals. The trigger data sheet was designed to monitor the presence or absence of triggers related to potential aspiration. The development of this data sheet is another positive step forward in better being able to identify signs and symptoms. The Facility had initiated some measures of health status both for individuals and for identifying trends. The Infection Control Program had developed a comprehensive database with the capacity to report on a wide range of infection control indicators. The database had not yet been fully populated with data. An Immunization database had also been developed but not fully populated. Both databases would assist the Facility to monitor health status of individuals. The Braden Scale to rate skin integrity was consistently completed. This is a good example of use of a recognized scale to evaluate health status. Although clinical data including the Braden scale were more completely reported in Nursing Quarterly and Annual Assessments, analysis and summarization of these data had not improved. Summaries contained statements of impressions that were subjective and did not describe the actual health status of the individual.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Provision of assessments on both a regular basis and in response to developments or changes in an individual's status was not consistent across all disciplines. Examples in which regular assessments were not done as scheduled or were not complete include: • Assessment of intellectual and adaptive function was not done routinely. As reported in Provision K5, psychological assessments did not contain findings from intellectual tests administered within the past five years or adaptive assessments conducted within the prior year. Furthermore, assessments of the function of problem behaviors did not consistently meet current, generally accepted standards. • As reported in Provision M3, Health Maintenance Plans were not always documented as having been reviewed at the time of Quarterly and/or Annual Comprehensive Nursing Assessments. • Communication assessment did not address 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. Although there were sections in the assessment that addressed verbal and nonverbal skills; the information contained in those sections was vague and did not provide useful information that would aid in the development of skills. Assessments also did not always occur in response to change in an individual's health status, as indicated by these examples: • Based on a review of 15 individual records, documentation supported that the PNM Team or PST did not meet regularly to address change in status such as occurrence of aspiration pneumonia or choking, indicators of increased risk, clinical data and monitoring results. • Facility staff referred to the IMRT as a restraint review body but that review was perfunctory with members not having documents and data to review. Any review that occurred at IMRT was based primarily on anecdotal information and the account of events presented by the Unit Director or Unit psychologist. There was no substantive combined clinical and administrative review of restraint episodes at the RSSLC nor was there a process in place to achieve this.	Noncompliance
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the	This provision has two requirements. One is that diagnoses are consistent with the DSM and ICD codes. The second is that diagnoses clinically fit assessments or evaluations.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Although most diagnoses were consistent with the conditions listed in the DSM and ICD codes, some did not. For example: • The Active Treatment List (APL) was to include all health issues to be addressed. The APL was typically included as a section of the individual's annual medical evaluation, and the APL was also filed as a separate item in the clinical record, immediately following the medical evaluation. The APL typically listed the psychiatric diagnoses that were listed in PBSP. Sometimes, however, the APL also listed non-DSM psychiatric diagnoses that were not found elsewhere in the clinical records. For example, the APL for Individual #91 included "Organic Personality Disorder," the APL for Individual #195 included "Mental Disorder due to Organic Brain," and the APL for Individual #596 included "Organic Personality with hyperactivity. " The term "organic" was not included in DSM IV, and the above diagnoses appear to have been retained from earlier diagnostic classifications. The APL for Individual #9 included "Neurotic Excoriation." In that case the error was also included in the PBSP. • Examples of diagnoses that did not match ICD codes was found for Individual #765. The Annual Medical Summary, dated 3/16/10 documented "spastic quadriplegic cerebral palsy", and "profound mental retardation with multiple contractures" as current medical diagnoses. These diagnoses did not comply with current ICD diagnosis codes. There were examples in which psychiatric diagnoses were not supported by assessments. • As reported in Provision J3, the Monitoring Team found that in many cases, changes in diagnoses made during Psychiatric and Behavior Management Clinics (PBMC) did not provide documentation that was needed to justify the changes in diagnoses. • During clinical chart reviews the Monitoring Teams also noted that several individuals seen during the PBMC had unresolved Rule Out (r/o) diagnoses in their diagnostic evaluations. • The lack of a database or other process to track and reconcile diagnoses meant that different parts of the clinical record contained different diagnoses.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions	Interventions were not always revised when progress was not occurring, as the following examples indicate: • For Individual#112, displays of aggression had been increasing over 4 months while other undesired behaviors declined. The progress review did not indicate	Noncompliance

#	Provision	Assessment of Status	Compliance
	shall be timely and clinically appropriate based upon assessments and diagnoses.	whether this intervention was considered successful or in need of revision. • For Individual #156, aggression and other undesired behaviors increased over six months while no strengthening of replacement behavior was documented. For each of the six months, progress notes contained the recommendation to continue the PBSP. • For Individual #174, data on self-injury had not indicated a consistent response to treatment over the previous 12 months. A safety plan was implemented in September of 2010, but documentation did not reflect any changes to the PBSP. There were also examples in which treatments and interventions were not revised when there were changes in health status. • Provisions O1 includes examples of individuals who had aspiration pneumonia or incidents of choking, but for whom no additional comprehensive assessment or change in intervention occurred. • Provision L1 reports examples in which acute changes in status were not reported, evaluated, and diagnosed timely. Medical and dental support plans had been developed for many individuals; however, documentation of implementation led the Monitoring Team to conclude implementation is not occurring as planned. For example: • Individual #321 had a medical support plan that was put in place in September, 2010. The Monitoring Team requested data sheets for January, February, and March 2011. Data sheets were not provided for February or March leading the Monitoring Team to conclude the plan had not been implemented during this time period. • Individual #223 had a dental support plan that was put in place on January 6, 2011. The Monitoring Team requested data sheets for January, February, and March 2011. From the documentation provided it appears this plan was first implemented on 3/24/11. • Individual #361 had a dental support plan that was put in place in November, 2010. The Monitoring Team requested data sheets for January, February, and March 2011. No data sheets were provided leading the Monitoring Team to conclude the plan had not been implemented.	
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	The Facility had begun development of determination of clinical indicators. A good example was the development and implementation of an "Acute Clinical Indicator" process. The process was intended to provide Clinical staff with greater insight in the management of acute medical conditions at the Facility. The Medical Director continues to develop the process and reported to the Monitoring Team that the Facility will implement a pilot program by the time of the next review.	Noncompliance

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	a clinically justified manner.	The Aspiration Trigger Data Sheet was implemented for all individuals. The trigger data sheet was designed to monitor the presence or absence of triggers related to potential aspiration. The development of this data sheet is another positive step forward in better being able to identify signs and symptoms. However, the availability, use, and documentation of clinical indicators continued to need improvement.The Facility included the clinical indicators to be monitored and the frequency of monitoring in two (11%) cases of individuals determined to be at risk reviewed by the Monitoring Team. Another example involved sensorimotor treatment interventions. Individuals who were referred to sensorimotor programs (care provided by PNMP Coordinators, DCPS, and PT tech) did not have their data collected in a manner that shows decline or progress. Data are collected either by sign off or by simply stating that the activity occurred. Furthermore, while PNMPs are reviewed at the PSP, there was not a system in place that clearly monitored the overall effectiveness of the plan. Although the Aspiration Trigger Data sheets had been implemented that allowed for the tracking of clinical indicators but there was not a system that allowed for review and analysis of the acquired data.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.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The Facility had initiated some measures of health status both for individuals and for identifying trends. This continued to be a work in progress. The Monitoring Team recognizes the improvements that have been made but concurs with the Facility that it does not yet comply with this provision. For example, as recorded for Provision M1, the Infection Control Program had developed a comprehensive database with the capacity to report on a wide range of infection control indicators. The database had not yet been fully populated with data. An Immunization database had also been developed but not fully populated. Both databases would assist the Facility to monitor health status of individuals. The Braden Scale to rate skin integrity was consistently completed. This is a good example of use of a recognized scale to evaluate health status. Although clinical data including the Braden scale were more completely reported in Nursing Quarterly and Annual Assessments, analysis and summarization of these data had not improved. Summaries contained statements of impressions that were subjective	Noncompliance

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		and did not describe the actual health status of the individual. For Physical and Nutritional Management, a policy/protocol that addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted does not exist at RSSLC. Lacking is: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Identification of monitors and their roles and responsibilities, o Monitors are re-validated on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms are correct and consistent among various individuals conducting the monitor, and o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician. The Monitoring Team recognizes the high quality of the Quarterly Drug Regimen Review (QDRR) process at the Facility, which provides a review of status of individuals in relation to the medications prescribed. A process to follow up QDRR recommendations to resolution would provide a valuable assessment of health status.	
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.	As reported in Provision H3, examples were documented in which review of clinical indicators did not trigger modification of treatments and interventions. In many cases, the evaluation of clinical indicators should lead to additional assessment, which did not occur consistently.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	A draft DADS state policy was available and this was an improvement since the last onsite review. It addressed provisions G and H together. The policy was not yet completed or disseminated. The majority of the policy addressed section H and appeared to be a good start to providing the facility with some guidance and direction. It might be helpful to indicate how the contents of the policy related to each of the specific seven provision items of provision H.For provision item H1, the policy listed some details about the regulatory or statutory requirements for a nursing quarterly review, an annual dental exam, a review of behavior control drugs, an annual physical, and a review of risk status. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services).	Noncompliance

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		The Facility had taken several other actions that should improve the review of clinical indicators and the use of indicators to trigger assessments and revisions in treatments and interventions. Although these have not yet led to compliance with provisions of this section, and additional actions will be needed, they should continue. These actions include: • The Integrated Morning Meeting • The development and expansion of the Acute Clinical Indicator process • The Skin Integrity Committee	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Continue the development of the Acute Clinical Indicators.
2. Complete populating data for the Infection Control and Immunization databases.
3. Consider establishing databases (or including information in current databases) for selected health indicators, such as occurrences of pneumonia, use of psychotropic and antiseizure polypharmacy, use of STAT medication or hospitalization for seizures, and other indicators for which information on trends could lead to improvement processes for the Facility to undertake. Consider coordinating this through or using the resources of the Quality Assurance Department.

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) 4/18/11 2. RSSLC Policy I.8 Health Status Team Guidelines (10/12/09) 3. RSSLC Policy I.15 Actions Following Choking Incident (4/29/03) 4. RSSLC Policy I.19 Responding to Weight Loss/Gain (2/11/10) 5. RSSLC Policy D.23 Using Bed Rails (3/16/06) 6. RSSLC Policy E.2 Crisis Intervention (5/1/03) 7. DADS At Risk Policy 006.1(1/1/11) 8. Integrated Risk Rating Form for Individuals #363 and #385 9. Samples of completed Health Risk Assessment Rating Tools 10. Nursing Care Plan to mitigate/manage risk for Individuals #223, #264, #479, #481, #573, and #797, 11. Record reviews of Individuals #6, #16, #25, #58, #84, #174, #223, #264, #267, #315, #316, #320, #385, #403, #471, #479, #481, #573, #797, and #798 12. PSPs for Individuals, #6, #16, #29, #30, #84, #96, #109, #134, #137, #149, #174, #175, #185, #199, #213, #274, #283, #316, #322, #347, # 363 ,#385, #440, #442, #471, #512, #513, #573, #641, #679, #771, #783, and #784 **People Interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. PNM Team (David Taylor OTR, Jean Cuevo PT, Sally Martinez RN, and Brandy Rabe SLP) 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 **Meetings Attended/Observations:** 1. PSPA meetings for Individual #52 and #477, 2. Group meeting with four QMRP's and QMRP Coordinator 3. Medical Nutrition Therapy Meeting 5/2/11 4. Pneumonia Meeting 5/3/11 5. PSP annual meetings for Individuals #96, #200, and #477 6. At Risk Team Meetings for Individuals #363 and #385 7. Meal observations on Trinity, Leon, and San Antonio 8. Risk Assessment meetings for Individuals #363 and #385
	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 Facility reported it had initiated and provided training on a revised risk assessment procedure and an Aspiration Trigger Data Sheet. The Monitoring Team's review substantiated this self-assessment.
	Summary of Monitor's Assessment:

	The RRSLC processes to demonstrate compliance with this section of the SA were insufficiently organized to achieve the desired results. The new statewide risk assessment procedure, with improved guidelines for rating risk, had been initiated. However, in nearly 90% of records sampled, risk assessments were not conducted within five working days of risk identification or a change in circumstances. Additionally, professional staff implementation of the Risk Assessment policy was inconsistent indicating a need for additional training and professional oversight. Interdisciplinary discussion required to properly assess risk and develop risk mitigation strategies was not apparent to the Monitoring Team. For example, in most records sampled, the Monitoring Team determined that assessments were not sufficiently comprehensive to enable interdisciplinary discussion. The lack of work flow organization, and professional oversight of the risk assessment process, prevents the RSSLC from identifying risk timely and appropriately, which in turn prevents the development of timely and appropriate risk mitigation plans. This places individuals living at the RSSLC unnecessarily at-risk.

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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 reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The new statewide risk assessment procedure, with improved guidelines for rating risk, had been initiated. The Monitoring Team observed three PSP meetings. Appropriate disciplines necessary for the risk discussion were present at two (67%) of the PSP meetings. A dietician was not present for the PSP for Individual #477. Because the Individual was outside his Ideal Body Weight (IBW) the presence of a dietician was viewed by the Monitoring Team as necessary to properly review and assess risk associated with this Individual . The staff present at the PSPs was the actual staff that worked with the individual in all (100%) three PSP meetings observed by the Monitoring Team. This included Direct Care Professionals. The individual was present at all (100%) three PSP meetings observed by the Monitoring Team. The PST used the Risk Level Guidelines established as part of the new state procedure for assessing and managing risk when determining risk levels for two (67%) of the PSP meetings observed by the Monitoring Team. This was not the case for Individual #200, as noted in examples below. PSP meetings observed by the Monitoring Team included open discussion among PST members although a great deal of the discussion was superficial and not based on clinical data. The PSTs worked through a checklist to ensure all required topics were	Noncompliance

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		reviewed/discussed but the PST used supporting clinical data when determining risks levels in none (0%) of the three PSP meetings observed by the Monitoring Team. The Monitoring Team did not observe any PST review that went beyond superficial consideration of the specifically described risk conditions in the Risk Guidelines and that would have led to clinically oriented discussion and resolution of any disagreements among PST members regarding risk levels. There was limited discussion addressing how risk impacted potential alternative placement, or affected the daily life of the individual. There was clinical discussion among appropriate team members in decisions regarding risk levels in none (100%) of the three PSP meetings observed by the Monitoring Team. For Individual #96 there was limited clinical discussion on two risk factors: challenging behavior and polypharmacy. The team provided adequate justification of designated risk levels in none (100%) of the three PSP meetings observed by the Monitoring Team, so there was no documentation to show appropriateness of the ratings of risk level. The PSP facilitator kept the team discussion focused in all three (100%) of the PSP meetings observed by the Monitoring Team. Some of the limitations of the PSP meetings observed by the Monitoring Team were evident in the following examples from the PSP for Individual #200 on 5/2/11: • In a discussion of the falls experienced by the individual, it was reported that the individual fell fewer than once per month. The data actually reflected that the individual had fallen at an average frequency of greater than twice per month. When the mother inquired about a recent fall in the bathroom, the nurse could not find documentation of the event. • The PST discussed the individual's chronic weight loss in relation to rumination. Several recommendations were offered, such as increasing the number of meals, walking, and distraction. At no point was it suggested that a comprehensive assessment of the rumination behavior should be conducted. A comprehensive behavior assessment would have helped the psychologist better understand the behavior, as well as the likely function and maintaining contingency of the behavior. Without such information, the probability of developing a successful intervention was substantially reduced and, therefore, risk was likely to remain high both in relation to weight loss and to the health risks of rumination, including aspiration. The Monitoring Team requested that two PSTs participate in special meetings to go through their reviews of risk for an individual. Clinicians closely followed the guidelines	

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		presented by the State policy but did not use professional judgment to adjust risk ratings as needed. Following this discussion, both teams revised risk ratings to reflect better the needs of the individuals for a heightened level of scrutiny for specific areas of 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 individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The RSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. Based on a review of 19 records for individuals initially determined by the PST to be at risk (Individuals #6, #16, #25, #58, #84, #174, #223, #264, #267, #315, #316, #320, #385, #471, #479, #481, #573, #797, and #798) there was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual being identified as at risk for two (11%) individuals. Records that did not contain documentation of this requirement included: Individuals #6, #16, #25, #58, #84, #174, #223, #264, #267, #315, #316, #320, #479, #481, #573, #797, and #798. The records of these 19 individuals' were reviewed to determine if changes in circumstance should have resulted in changes to an at-risk assessment, rating, and plan. There was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual changes in an at-risk condition for two (11%) individuals. Based on a review of records of six individuals for whom assessments had been completed to address the individuals' at risk conditions, two (33 %) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individuals #479, #481, #797, and #264. The following provides an example of an assessment that was not comprehensive: For Individual #264 the historical data necessary to complete an adequate nursing assessment was incomplete, covering only aspiration, GI problems, and dental. Based on a review of records of seven individuals for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individuals #6, #16, #84, #316, #385, #403,and #471. The following provides an example of an assessment that was not comprehensive: Individual #403 should have liquids held until the end of the meal but there was no description as	Noncompliance

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		to what swallowing issues this strategy addressed. Based on a review of records of seven individuals(Individuals #25, #58, #174, #267, #315, #320, and #798) for whom assessments had been completed to address the individuals' at risk conditions, six (86%) included an adequate psychiatric assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #267. The following provides an example of an assessment that was not comprehensive: Individual #25 was identified at high risk due to challenging behaviors. There were four objectives: • To increase active treatment, action steps proposed were to continue the PBSP. • To decrease meal refusals, the action steps proposed were to continue the PBSP. • To increase all targeted (behaviors), the action steps were to continue thePBSP. • To minimize restraints the action steps were to follow-up in psychiatry clinic and to follow the PBSP. The plan was too general and non-specific, given the level of risk. Other plans reviewed were similarly deficient with respect to specificity. There were several examples of risk events or changes in status related to physical and nutritional management, butneither the PST nor PNMT met regularly to address change in status, assessment, clinical data and monitoring results. Theseincluded: • Individual #6 was diagnosed with aspiration pneumonia on 7/5/10. There was no PST or PNMT response to the incident. • Individual #16 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 #84 was diagnosed with aspiration pneumonia on 5/21/10 and 1/6/11. 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 or PST met to discuss the issue. • Individual #347 had a choking event on 11/14/10. There was no evidence of a comprehensive oral motor assessment to determine if there was a decline in swallow function. • Individuals #149, #322, 512 had swallow studies completed but there was no evidence of PST or PNMT review of findings. Additionally, members of the PST were not consistently attending meetings in which	

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		their expertise was needed. For example, Individual #385 was diagnosed with aspiration pneumonia on 11/3/10. There was no evidence of OT or SLP involvement in the PST meetings on 11/1/10 or 12/3/10.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The RSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. Based on a review of 19 records for individuals determined to be at risk (Individuals #6, #16, #25, #58, #84, #174, #223, #264, #267, #315, #316, #320, #385, #471, #479, #481, #573, #797, and #798), there was documentation that the Facility: ▪ Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in two (11%)) cases. Records that did not contain documentation of this included: Individuals #6, #16, #25, #58, #84, #174, #223, #264, #267, #315, #316, #320, #479, #481, #573, #797, and #798. ▪ Implemented a plan that met the needs identified by the IDT assessment in four (21%) cases. Records that did not contain documentation of this included: Individuals #6, #16, #25, #58, #84, #174, #264, #267, #315, #316, #320, #471, #479, #481, and #798. ▪ Included preventative interventions in the plan to minimize the condition of risk in two (11%) cases. Records that did not contain documentation of this included: Individuals #6, #16, #25, #58, #84, #174, #264, #267, #315, #316, #320, #471, #479, #481, #573, #797, and #798. ▪ When the risk to the individual warranted, took immediate action in one (5%) cases. Records that did not contain documentation of this included: Individuals #6, #16, #25, #58, #84, #174, #223, #264, #267, #315, #316, #320, #471, #479, #481, #573, #797, and #798. ▪ Integrated the plans into the PSPs in four (21%) cases. Records that did not contain documentation of this included: Individuals #6, #16, #25, #58, #84, #174, #264, #267, #315, #316, #320, #479, #481, #797, and #798. ▪ In two (11%), the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. Records that did not contain documentation of this included: Individuals #6, #16, #25, #58, #84, #174, #264, #267, #315, #316, #320, #385, #471, #479, #481, #797, and #798. ▪ In one (5%), appropriate functional and measurable objectives were incorporated into the PSP to allow the team to measure the efficacy of the plan. Records that did not contain documentation of this included: Individuals #6, #16, #25, #58, #84, #174, #223, #264, #267, #315, #316, #320, #471, #479, #481, #573, #797, and #798. ▪ Included the clinical indicators to be monitored and the frequency of monitoring	Noncompliance

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		in two (11%) cases. Records that did not contain documentation of this included: Individuals #6, #16, #25, #58, #84, #174, #264, #267, #315, #316, #320, #385, #471, #479, #481, #797, and #798. The following is anexample of a plan that was adequate to address one of the at-risk factors identified for Individual #58: The plan to reduce polypharmacy for Individual #58 included detailed monthly reviews for polypharmacy, supported by side effect screening and other observation of the psychiatrist, psychologist, nurse and other PST members. General guidelines regarding the circumstances that would allow medication reductions were included in the psychiatric assessment. The following is an example of a plan that was inadequate to address the at-risk factors identified for Individual #25: Individual #25 was identified at high risk due to challenging behaviors. There were four objectives. To increase active treatment, action steps proposed with to continue the PBSP. To decrease meal refusals, the action steps proposed were to continue the PBSP and to follow it. To increase all targeted (behaviors), the action steps were to continue and to follow the PBSP. To minimize restraints the action steps were to follow-up in psychiatry clinic and to follow PBSP. The plan was too general and non-specific, given the level of risk.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should assure all PSTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the new PSP process. QMRPs/Team leaders should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the PSP process.
2. Ensure that appropriate and timely assessment and revision of the PSP is done for any individual whose level of risk is revised as the At-Risk Individuals policyis implemented.

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 updated 04/18/11 2. DADS Policy 008 Psychological and Behavioral Services 02/16/11 3. DADS Policy 001 Use of Restraint 09/22/09 4. RSSLC Procedure J11: Behavior Intervention: Using Sedation for Medical/Dental Appointments/Behavioral Symptoms 5. RSSLC Procedure J3: Implementing Dental Support Treatment Support Plan 6. RSSLC Behavioral Incident Review (BIR) form 7. RSSLC Nursing form: Medical Monitoring of an Episode of Acute Illness/Sedation 8. RSSLC Nursing form: Parenteral Sedation (TIVA) Anesthesia Recovery 9. RSSLC Nursing form: Medical Monitoring Form 10. Clinical Record Reviews for Individuals #9, #17, #29, #70, #76, #77, #91, #101, #195, #199, #212, #252, #267, #273, #315, #346, #353, #364, #404, #415, #429, #439, #447, #455, #456, #499, #513, #523, #531, #568, #596, #613, #636 #645, #714, #771, and #800 11. Appendix B psychiatric evaluations for Individuals #16, #29, #36, #48,#119, #124, #128, #140, #144, #145, #152, #179, #181, #210, #212, #225, #232, #282, #340, #347, #353, #355, #361, #369, #390, #405, #422, #424, #426, #439, #456, #459, #467, #483, #487, #493, #523, #525, #529, #555, #584, #598, #614, #641, #647, #649, #680, #691, #713, #744, #747, #760 #764, and #784 12. Medical pretreatment sedation records for Individuals #254 (10/14/10), #353 (01/03/11), #369 (11/10/10), and #399 (12/21/11). 13. Dental pretreatment sedationrecords forIndividuals #199 (10/04/10), #296 (03/28/10), #551 (10/25/10), #555 (11/01/10), and #598 (12/07/10) 14. Total intravenous sedation (TIVA) records for Individuals #145 (11/15/10); #148 (12/09/10); # 207 (02/03/11) and #525 (11/16/10). 15. Risk assessments for Individuals #25, #58, #174, #267, #315, # 320, and #798 16. Review of episodes of multiple restraints for Individuals #174, #429, and #630 **People Interviewed:** 1. Ambrose Banor RN, Case Manager 2. William Eckenroth, PhD, Behavioral Services Director 3. Shelley Evan, Associate Psychologist V 4. Carol Heath, DDS, Dental Director 5. Lindsey Knott , Psychiatric Assistant 6. Elizabeth Ohiku, MD, Staff Psychiatrist 7. Tran Quan, DO, Director of Medical Services 8. Larry Sanxter, MS, Behavior Analyst 9. Michael Shatz, Pharm D., Clinical Pharmacist 10. Emma Wilson, Behavior Analyst

	Meetings Attended/Observations: 1. Psychiatric and Behavior Management Clinic, 05/03/11 2. Integrated Clinical Meeting, 05/04/11 3. Risk Assessment Meeting, 05/04/11 4. Review of Medical/ Dental Pretreatment Sedation and TIVA, 05/04/11 5. Pharmacy and Therapeutics Committee (P&TC) Meeting, 05/04/11
	Facility Self-Assessment: The Facility reported that it complied with two of the fifteen provisions of the psychiatry section of the SA. The Facility self- assessed compliance with professional staffing requirements. All four psychiatrists employed by the Facility were board certified in their specialty. The Facility also self–assessed compliance with SA requirements for the use of the Reiss Screen for Maladaptive Behavior. Screening had been completed for all individuals who required them, and a process for psychiatric evaluations was underway for individuals who required them. The Monitoring Team concurred with these self-assessments of the Facility. The Facility also reported that systems were in place for monitoring, detecting, and reporting side effects of medications, and for a facility-level review of psychiatric polypharmacy practices. The Monitoring Team agreed that these processes were in place and the relevant provision in substantial compliance with the SA requirements. The Facility reported progress in the coordination between psychiatry and neurology regarding the use of medications prescribed to treat both seizures and mental health disorders, and reported progress with the program to minimize the need for medical restraints. The Monitoring Team concurred that there had been some progress in those areas. The Facility reported some progress in the areas of psychiatric evaluations and diagnosis, the appropriate use of psychotropic medications, and combined assessment and case formulation. The Monitoring Team found that in these areas substantial work remained.
	Summary of Monitor's Assessment: **For Provision J1:** The provision remained in substantial compliance: The Facility employed three contract psychiatrists and one staff psychiatrist. All psychiatrists were board certified, and all had sufficient experience with intellectual disabilities. The staff psychiatrist actively and appropriately participated in the interdisciplinary process. **For Provision J2:** The provision was determined to be not in compliance. The provision required that mechanisms should be in place for all psychotropic medications to be based on clinically justifiable evaluations and diagnoses. However, the Monitoring Team found that in many cases different diagnoses

	were cited in the various sections of an individual's clinical record, that many individuals had unresolved "not otherwise specified" (NOS) or "rule out" (r/o) diagnoses, and that the cited diagnoses were not linked to specific behavioral characteristics of proposed disorders. **For Provision J3:** The provision was determined to be not in compliance. There was some improvement in the area of the appropriate use of psychotropic medications. However, clinical records often did not indicate the reasons that various psychotropic medications were prescribed, and medication treatments were not linked to specific behavioral characteristics of proposed disorders. **For Provision J4:** The provision was determined to be not in compliance. The Facility had a credible program to reduce the need for pretreatment sedation. However, that program had not yet been applied to all individuals who received pretreatment sedation for routine medical and dental procedures, and efforts to develop quality assurance procedures for the program were still under development. In addition, oral pretreatment sedation and total intravenous sedation (TIVA) constituted medical restraint, and some facility practices did not comply with current DADS guidelines for medical restraint. **For Provision J5:** The provision was determined to be not in compliance. A full time psychiatrist had resigned, and the facility did not have a sufficient number of psychiatrists to provide the services required by the SA. **For Provision J6:** The provision was determined to be not in compliance. The Facility had successfully deployed the use of Appendix B evaluations for about 140 individuals. However, the evaluations for many individuals did not fully follow the required format, the evaluations did not provide required justifications for diagnoses, and many individuals had unresolved "NOS" or "r/o" diagnoses. **For Provision J7:** The provision was determined to be not in compliance. Reiss Screens were administered to all individuals who required them, and a process was underway to complete psychiatric evaluations for all individuals who required them; when the evaluations have been completed, this provision should reach substantial compliance. **For Provision J8:** The provision was determined to be not in compliance. The Monitoring Team confirmed that behavioral data were considered in decisions regarding pharmacological treatments. However, a process was not in place to provide integrated behavioral care through combined assessment and case formulation. **For Provision J9:** The provision was determined to be not in compliance. An adequate process was not in place for Personal Support Teams (PSTs) to select and assign appropriate modalities for the treatment of behavioral disorders, and the treatments individuals received were not properly described in PBSPs. **For Provision J10:** The provision was determined to be not in compliance. Adequate procedures were not in place for the PST (including the psychiatrist, primary care physician [PCP] and nurse) to evaluate risk benefit evaluations of proposed medication treatments, and to consider alternative treatments.

	For Provision J11: The provision was determined to be in substantial compliance. Monthly reviews were conducted in the psychiatric clinics for all individuals who were treated with psychiatric polypharmacy. Also, the Facility had established a committee to provide facility-level reviews of polypharmacy practices, and to assure that medication reduction plans were in place for individuals who needed them. **For Provision J12:** The provision was determined to be not in compliance. Individuals received required screen for medication side effects, and the Facility had established a process for facility-wide monitoring of the results of the screening. However, the Facility did not have a process to track new prescriptions of psychotropic medications or changes in dosage and could therefore not ensure tracking of side effects was done as needed other than at regularly scheduled assessments. **For Provision J13:** The provision was determined to be not in compliance. The Facility did not have a system for psychotropic medication treatment plans. **For Provision J14:** The provision was determined to be not in compliance. Since there were no medication treatment plans, legally authorized representatives (LARs) could not be properly informed about proposed medication treatments. **For Provision J15:** The provision was determined to be not in compliance. The staff psychiatrists attended neurology clinics, but difficulties remained in the coordination of neurological and psychiatric care.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	There were four psychiatrists at the Facility. Dr. Ohiku worked on a full time basis and she was the Lead Psychiatrist. Drs. Hermant Patel and Dominic Joseph were contract psychiatrists who were primarily responsible for psychiatric evaluations. Each worked 8-10 hours per week. Dr. Rafael Guerrero was a contract psychiatrist who conducted Psychiatric and Behavior Management Clinics (PBMC). Dr. Guerrero worked about 18 to 20 hours per month. All psychiatrists were board certified by the American Board of Psychiatry and Neurology. Dr. Ohiku was also board certified in Child and Adolescent Psychiatry. Dr.. Patel had additional board certifications in Forensic Psychiatry.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive	The Monitoring Team reviewed the manner in which the Facility provided psychiatric evaluations and diagnoses. All of Dr. Joseph and Patel's time was spent on diagnostic evaluations for individuals who lived at the Facility and who received psychiatric care. At the time of the last compliance tour 94 such evaluations had been completed. Since that tour, Dr. Patel completed an additional 19 evaluations, and Dr. Joseph completed	Noncompliance

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	psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	another 31 evaluations. Dr. Ohiku completed diagnostic evaluations on individuals who were newly admitted to the Facility. Since the last compliance tour she completed four such evaluations. Together, the psychiatrists completed 54 new evaluations. In addition to comprehensive psychiatric evaluations, new diagnoses were added and revisions to existing diagnoses were made during psychiatric and behavior management clinics (PBMCs). In these clinics, individuals met with their treating psychiatrist and with other members of their Personal Support Teams (PST). Dr. Ohiku was the treating psychiatrist for about 60 individuals, and Dr. Guerrero was the treating psychiatrist for about 100 individuals. The Monitoring Team reviewed clinical records, to determine whether the diagnoses provided to individuals were clinically justifiable. This determination was made on the basis of the criteria provided by Appendix B of the SA, Section XII. Documented justification of diagnoses needed to be in accord with DSM IV-TR criteria. Differential diagnoses, "deferred" or "r/o" diagnoses, and diagnoses listed as "not otherwise specified" (NOS) needed to be resolved in a timely manner, i.e. within 60 days. The Monitoring Team's overall review of the 54 recently completed Appendix B evaluations is provided in the discussion for provision J6, which focused exclusively on those evaluations. The report in this provision is limited to the issue of whether or not the diagnoses made by psychiatrists met the criteria listed above. Although the underlying evaluations were very comprehensive and contained a wealth of valuable clinical information, in many cases the evaluations did not provide needed justifications for diagnoses that were needed. For example: • Individual #16 was diagnosed on axis I with autism, pica, and obsessive compulsive disorder (OCD). The history of present illness and psychiatric history sections of the evaluation provided adequate information to support the diagnosis of pica, but very little was provided to support the other two diagnoses: Hand biting and hand mouthing were repeatedly mentioned as target behaviors, and in the mental status exam the psychiatrist reported that the Individual was noted to be "*rocking, and at one point got up from the chair and was jumping up and down*." In the comprehensive treatment plan and recommendation section the psychiatrist stated that *"the patient's repeated hand biting and hand mouth behavior has been looked at as a compulsive behavior..."*No further information that could have been relevant to the diagnoses of autism or OCD was provided, and the diagnoses were made without comment or justification. • Individual #459 was similarly diagnosed with both autism and OCD on axis I, and profound retardation on axis II. The evaluation cited slow growth and development; the Individual started saying simple words at around age two and a half. The Individual did not interact with peers or initiate social contact, but he	

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		enjoyed attention from familiar staff, particularly males. The individual liked to rock his body and grind his teeth. The mentioned diagnoses were presented (along with others) without commentary. In both cases the psychiatrist did not provide adequate information to justify the diagnoses made. In both cases, a statement was also needed to clarify why diagnoses of autism and OCD were both needed, since repetition/stereotypy is part of the core diagnostic criteria for autism. Typically, the decision whether or not to list both diagnoses is a matter of clinical judgment. For example, the psychiatrist might have assessed that the degree of repetitiveness was more than could reasonably be attributed to autism alone. In other circumstances, the topography of the behavior itself is sometimes sufficient to distinguish stereotypy from other repetitive behaviors. Justification of the diagnoses did not need to be extensive and in many circumstances could be provided in a few sentences. However, some explanation/justification was needed. The Monitoring Team also reviewed the 54 Appendix B evaluations to determine whether "not otherwise specified" (NOS) and "rule out" (r/o) diagnoses were resolved in the required manner. The following paragraphs describe how many individuals had each one. The Monitoring Team recognized that some individuals had both NOS and r/o diagnoses. As a result there was some duplication in the frequency counts: The Monitoring Team found that 13 of the 54 evaluations (24%) contained unresolved NOS diagnoses. These were evaluations #16, #145, #212, #340, #353, #369, #426, #439, #487, #555, #747, #760, and #784. In a related matter, the Monitoring Team also examined the evaluations of individuals who had a diagnosis of intermittent explosive disorder (IED). IED is not listed in the DSM IV as an NOS diagnosis, but in order to make the diagnosis, the clinician must have assessed that degree of aggressiveness expressed during episodes is grossly out of proportion to any precipitating psychosocial stresses. It is a diagnosis that is difficult to make in setting of the more challenging levels of intellectual disability, discussed in the Diagnostic Manual for Intellectual Disabilities (DMID). The diagnosis of IED was not prohibited by the guidelines of Appendix B, but the Monitoring Team found that clarification/justification of its use was needed. Seven individuals (Individuals #128, #225, #355, #424, #456, #483, and #525) had diagnoses of IED, and these individuals did not have justification statements regarding the use of these (or discussion of the how the diagnosis might be ruled out). The Monitoring Team found that, 22 of the 54 evaluations (40%) had unresolved "rule out" diagnoses. These were the evaluations for Individuals #48, #128, #145, #152, #181, #210, #212, #347, #353, #422, #424, #439, #456, #459, #483, #487, #523, #529, #641, #680, #747 and #760.	

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		To understand further how diagnoses were made and justified at the Facility, the Monitoring Team requested a list of any individuals for whom the psychiatric diagnoses had been revised during the past six months. The Monitoring Team requested information about new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s). Information about changes in diagnosis was provided for 26 individuals. They were Individuals #9, #29, #70, #76, #101, #195, #212, #252, #267, #273, #315, #353, #364, #429, #439, #447, #455, #456, #499, #513, #523, #531, #645, #714, #771, and #800. All the changes were made during PBMCs. The Monitoring Team reviewed each of the examples. The Monitoring Team found that many of the changes in diagnoses made during PBMCs represented needed clarifications or updates to existing diagnoses. For example, for Individuals #273, #364, #439, and # 523, the diagnosis was changed from mood disorder secondary to a general medical condition to mood disorder secondary to seizure disorder. In some cases the psychiatrist clarified specifics. For example, in the case of Individual #364 the psychiatrist noted that the individual was typically agitated before seizures. In the case of Individual #531 the psychiatrist changed the diagnosis from mood disorder due to seizures, to mood disorder due to hip pain. That Individual had not had any seizures for many years but did have ongoing hip pain. Some cases were diagnostic updates that removed diagnoses that were no longer needed. For example, Individual #212 had a diagnosis of anxiety, that was related to prescriptions of Klonopin. The psychiatrist clarified that the individual received the medication for a medical condition (spasticity), commented that there was no need for the diagnosis of anxiety, and removed the diagnosis. Individual #771 was diagnosed with both autism and obsessive compulsive disorder (OCD). The psychiatrist determined that autism alone was sufficient to account for the stereotypy that was observed, and the diagnosis of OCD was removed. The Monitoring Team also found that in many cases, changes in diagnoses made during Psychiatric and Behavior Management Clinics (PBMC) did not provide documentation that was needed to justify the changes in diagnoses. For example: • Individual #9 was seen in the PBMC on 02/28/11. The individual was diagnosed with autism, trichotillomania, and pica. The Individual had no changes in medication since 2008. The Individual's pica and trichotillomania were related to anxiety and both had resolved. The diagnoses of pica and trichotillomania were changed to a history of those disorders, and the diagnosis of OCD was added. However, the psychiatrist also stated that the basis for the diagnosis of OCD was not clear. The Monitoring Team could not tell why the diagnosis of OCD was added.	

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		• Individual # 101 was seen in PBMC on 01/14/11. The psychiatrist reported that the individual was diagnosed with personality change due to hypoxia at birth. The psychiatrist stated "*according to Staff, the patient displays intermittent agitation and aggression….according to the behavior data (the Individual) continues to display refusal, aggression and inappropriate behavior…. I recommend changing the diagnosis to IED."* More detail was needed to establish the basis for a diagnosis of IED since learned behavior or instrumental aggressions were also possibilities. • Individual #195 was diagnosed with mood disorder due to closed head injury and was treated with two psychotropic medications for that disorder. The individual was seen in PBMC on 02/18/11. The psychiatrist recommended a change in the diagnosis to major depressive disorder secondary to traumatic brain injury. The psychiatrist did not comment on the reasons for the change, and did not provide needed detail on the manner in which the individual met diagnostic criteria for major depressive disorder. • Individual #252 was diagnosed with intermittent explosive disorder and autism. The psychiatrist discontinued the diagnosis of IED, and added the diagnosis of bipolar disorder, most recent episode manic, severe, without psychotic features. No details were provided to explain the change in diagnosis and insufficient details were provided to clarify that the Individual met diagnostic criteria for the new diagnosis. • Individual #455 was diagnosed with dysthymia and intermittent explosive disorder. The individual was seen in PBMC on 01/04/11, and the psychiatrist changed the diagnosis from dysthymia to bipolar disorder NOS. The psychiatrist did not comment on the reasons for the change, did not justify the diagnosis of bipolar disorder, and did not discuss how the NOS issue would be resolved. • Individual #456 was diagnosed with OCD and a seizure disorder. During the clinic the psychiatrist stated: *"I recommend changing the psychiatric diagnosis to IED. The patient displays OCD features such as a rigid pattern of behavior. However, staff did not report any significant compulsive behaviors. On the other hand the aggression is impulsive and intermittent; therefore, it seems appropriate to use a diagnosis of intermittent impulsive (sic) disorder."* A more detailed justification to explain the use of IED was needed. • Individual #513 was diagnosed with psychotic disorder NOS and was seen in PBMC on 03/26/11. The psychiatrist stated that the Individual *"continued to display aggressive behaviors. According to Staff, these odd behaviors occur primarily at the dorm. … There are reports that are suggestive of psychosis. I would recommend using a diagnosis of schizoaffective disorder and removing the diagnosis of psychotic disorder NOS."* The description was not sufficient to justify the new diagnosis.	

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		• Individual #645 was diagnosed with autism and OCD, and was treated with Zyprexa and Ativan. For both medications the relevant target symptoms were saliva throwing and social isolation. The individual was seen in PBMC on 02/12. In the note from the clinic the psychiatrist stated *"I recommend changing (the Individual's) diagnosis from OCD to generalized anxiety disorder. The patient however does display OCD features."* The psychiatrist did not provide adequate justification for the new diagnosis and did not provide appropriate behavioral characteristics. It is possible the social isolation was such a symptom, but if so that should have been discussed, along with the reasons that the diagnosis of social anxiety was rejected. • Individual #800 was diagnosed with Schizoaffective Disorder. The individual was seen in PBMC on 03/11/11. The behavior analyst provided a report that described that Individual's apparent anxiety and restlessness and gave examples. The psychiatrist stated that the *individual "also meets the criteria for generalized anxiety disorder (GAD)."* The psychiatrist should have discussed how the individual met diagnostic criteria for GAD, and why a second diagnosis was needed. The Monitoring Team inquired about the way that the Facility recorded and tracked diagnoses and diagnostic updates. The Monitoring Team requested a list of all individuals who received psychiatric care and their psychiatric diagnoses, but the Facility could not provide such a list. Upon inquiry, the Monitoring Team learned that the Facility did not have a common data base that recorded individuals' accepted psychiatric diagnosis. Examination of clinical records demonstrated that in many cases, different psychiatric diagnoses were listed in various sections of the clinical record, for example in psychiatric evaluations, in PBSPs, in medical summaries and Active Problem Lists (APL), in PBMC notes, and in the pharmacy database. Examples of individuals for whom there were discrepancies between diagnoses recorded in different parts of the clinical record were Individuals #9, #17, #77, #91, #101, #195, # 252, #273, #346, # 404, #415, #429, #455, #456, #513, #596, #613 #636, #645, and #800. During the PBMC clinic attended by the Monitoring Team, efforts had to be made by the clinical pharmacist, the behavior analyst, and the psychiatrist to update manually their individual records of an individual's diagnosis. The staff psychiatrist confirmed her participation in monthly conferences lead by the DADS Medical Director and attended by psychiatrists from the various SSLCs. These conferences included clinical case discussions and review of diagnostic issues common to individuals diagnosed with both an intellectual disability and a mental health disorder. The staff psychiatrist had also attended a national conference of an organization dedicated to the support of individuals who had dual diagnoses. The Monitoring Team recognizes the value of these opportunities.	

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J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	In this provision, the Monitoring Team assessed whether psychotropic medication use by the Facility was appropriate. The majority of psychiatric medication management took place at the Facility during PBMCs. Each of the 160+ individuals who lived at the facility and who received psychiatric medication(s) was seen in at PBMC at least quarterly, and individuals treated with psychiatric polypharmacy were seen monthly. Dr. Ohiku had a half day PBMC every week, and Dr. Guerrero had a full day PBMC twice every month. The Monitoring Team attended Dr. Ohiku's weekly clinic, which lasted about four hours. Individuals #9, #17, #77, #199, #346, #404, and #613 were seen during the clinic. The psychiatrist, clinical pharmacist and senior behavior analyst attended the entire clinic. Each clinical appointment was attended by the individual who was reviewed, and by that individual's nurse case manager, behavior analyst, social work and/or QMRP, and direct care professionals. Each appointment lasted about 30 minutes. Before the PBMC, behavior analysts had prepared consultation reports for each individual that provided summary information about the individual, for the period of time since that individual's previous PBMC appointment. During the PBMC the psychiatrist completed a form that was developed by Dr. Ohiku and Ms. Shelly Evan, Associate Psychologist V. The form included entries for the psychotropic medications, psychiatric diagnoses, symptoms /behavioral characteristic that related to the each medication, social functioning, occupational functioning, diagnostic assessment, polypharmacy details, medication response and general indications for further care. The general format for each appointment was that the psychiatrist examined/interviewed the individual. The clinical pharmacist reviewed laboratory data and informed the group about pharmacological issues such as drug interactions and drug metabolism. The behavior analyst presented data on target behaviors, and the nurse provided general health and side effect information. The assembled team discussed data from the PBSP, labs, DISCUS and Moses scores, and data on target behaviors, and general discussion followed. The Monitoring Team found the clinic was conducted in a professional manner; the care provided reflected high clinical standards of care and provided highly integrated care. However, in many cases the Monitoring Team witnessed clinical/administrative challenges that impacted negatively clinician's efforts to provide appropriate medication use. These difficulties are illustrated in the paragraphs that follow, by description of each of the seven clinic appointments. • Individual #9 was described in the PBMC note as diagnosed with autism, pica and trichotillomania. The individual was treated with Luvox and Risperdal. Diagnoses associated with the medication were trichotillomania, pica and OCD. Psychiatric diagnoses associated with Risperdal were "neurotic excoriation" and	Noncompliance

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		autism. The Target symptoms were listed as aggression to self and pica (Luvox) and aggression to self (Risperdal). The psychiatrist performed a good mental status exam, and there was a good discussion of the individual's recent successful sigmoidectomy. The clinical pharmacist provided a detailed review of laboratory and pharmacy data. Subsequent record review by the Monitoring Team found that the individual had not had a diagnostic evaluation. Nonetheless, the psychiatrist had added a diagnosis of OCD in PBMC in early February 2011, but that diagnosis was not reflected in the PBSP that was prepared later that month. "Neurotic excoriation" (skin picking) was erroneously listed in the PBMC and PBSP as a psychiatric diagnosis and that error was carried over as a listing in the pharmacy records. Pica was a target symptom for treatment with Luvox, and aggression to self was listed as a symptom for treatment with both Luvox and Risperdal medication treatment. There was no treatment plan for the use of Luvox and Risperdal, and no psychiatric symptoms were listed for tracking response to these medications. • Individual #17 was described in the PBMC note as having Obsessive Compulsive Disorder. The individual was treated with Prozac, Zyprexa and Lamictal, for aggression and self injury. Clinical discussion focused on the individual's urinary symptoms, and the individual's complaint of hand tremor. Data was presented about sleep, problems with aggression and an attempted elopement. There was discussion about paranoid delusions. Lamictal was presented as a "dual purpose" medication for both seizures and mood. The psychiatrist suggested that there was a need for diagnostic clarity regarding mood disorder not otherwise specified and to rule out bipolar disorder. Recommendations were made for medical follow-up for urinary symptoms and for changes in mental health therapy. Subsequent record review by the Monitoring Team found that the individual had recently had a full psychiatric evaluation which stated that the diagnosis was not OCD, but mood disorder due to general medical conditions including agenesis of the corpus collosum, with additional considerations to rule out delusional disorder, impulse disorder not otherwise specified and factitious disorder. The Psychiatric Evaluation listed psychiatric medications as Zyprexa and Prozac, but not Lamictal. Lamictal was presented in the PBSP only as a seizure medication, but it was nonetheless listed with other medicines as a "drug for behavior management." The PBSP also listed Lyrica, another seizure medicine, as "drug for behavior control," but that medicine was not mentioned by the PBMC. The Monitoring Team noted that agenesis of the corpus collosum was an anatomical finding that was highly pertinent to the behavioral presentation and to the conduct of mental health therapy. However, there was no mention of the condition in the PBMC presentation. In summary, Individual #17 had no agreed upon psychiatric diagnosis, and there was no agreement about which medicines were prescribed for psychiatric purposes. The clinical	

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		records raised the possibility the Lamictal and/or Lyrica were used as dual purpose medications for both psychiatric and medical conditions, without proper informed consent for the psychiatric use. The individual did not have medication treatment plans, and there was no formal monitoring for those medications. • Individual #77 was described in the PBMC records as having a diagnosis of Bipolar Disorder. The Individual was treated with Prozac and Zyprexa. Mood and psychosis were listed as psychiatric symptoms to be tracked for treatment with Zyprexa, and depression was listed as the symptom to be tracked for Prozac. However, there was no formal monitoring for these symptoms. The psychiatrist conducted a good mental status exam, discussed the symptom of skin picking, and raised the possibility that the antipsychotic medication might not be needed. Monitoring Team review of the clinical record showed that the psychiatric evaluation for this individual had raised the need to rule out the diagnosis of psychiatric disorder due to general medical condition. There was no record of efforts to resolve that issue. • Individual #199 was described in PBMC records as having a diagnosis of Bipolar Disorder. The individual was medicated with Seroquel, Inderal, Lamictal and Lithium. Symptoms to be tracked were listed as aggression and noncompliance. In addition, mood and psychosis were listed as symptoms to be tracked for Seroquel and Lamictal, and mood was listed as a symptom to be tracked for lithium. The team reviewed the individual's daily activities and interactions with a roommate; labs were reviewed. A recent seizure was noted, and as a courtesy to the treating neurologist, the Depakote dose was adjusted (Depakote was not a dual purpose medication, and was prescribed only for seizures). Monitoring Team review of the clinical record revealed a discussion by the consulting psychiatrist of a possible diagnosis of post traumatic stress disorder (on the basis of sexual abuse by a relative). There had been no follow-up to that "rule out" diagnosis, and it has not been resolved. It is important to follow up on such discussions of possible diagnosis to gain diagnostic clarity and assure the medications prescribed are related to the diagnoses. • Individual #346 was listed in PBMC records as having intermittent explosive disorder and generalized anxiety disorder. The Individual was treated with Zyprexa and Depakote. According to the PBMC the Depakote was prescribed for seizures, but according to the PBSP it was also prescribed for aggression. Neither medication was tracked with any psychiatric symptoms. The psychiatrist commented that there was initial "positive" response to lithium, and properly asked for a lithium level, but lithium was not listed on the PBMC form, and there was no information on why it was used or how it was to be tracked. The psychiatrist properly referred to urology for input on possible bladder	

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		spasms/urgency. Monitoring Team review of the clinical record found that the diagnosis of generalized anxiety disorder was listed on the PBMC and was not listed on either the PBSP or in the full psychiatric evaluation the individual had received. • Individual #404 was listed in PBMC records as having schizophrenia, and was medicated with Risperdal. No psychiatric symptoms were provided for tracking the psychiatric medication. During the clinic the psychiatrist performed a good mental status examination and there was good discussion about sedation that could be related to Risperdal and a discussion about ongoing dose reduction. There was discussion about possible anxiogenic effects of Keppra. Monitoring Team review of the clinical record showed that the diagnosis of schizophrenia (with a rule out of traumatic brain injury) came from the psychiatric evaluation, but according to the PBSP the diagnosis was major depression. Review of notes from the neurology clinic revealed that there was no agreed upon decision as to whether the individual did, or did not, have seizures. The PBMC stated "no history of seizure." The issue was particularly meaningful, given the concerns about treatment with Keppra. Although there was good clinical discussion and appropriate clinical steps were taken, there was no agreed upon diagnosis, no psychiatric symptoms were provided for tracking the treatment with Risperdal, no treatment plan for the use of that medication, and the individual continued to receive treatment with an anticonvulsant medication that may not have been needed, which could have worsened the known psychiatric symptoms. • Individual #613 was listed in PBMC records with intermittent explosive disorder and personality change due to head injury. The individual was treated with Risperdal, propanolol and Depakote. Risperdal was listed as an antipsychotic, propanolol was listed as a treatment for "aggression" and Depakote was listed as a dual purpose anticonvulsant and anti-manic. No formal psychiatric data were presented to support these listings. The team had a good discussion that Risperdal seemed to have a partial response based on general discussion about levels of "psychosis," and accordingly the dose was increased. There was a good review of labs, and discussion of risk factors (obesity and increase triglycerides). Monitoring Team review of the clinical record found that although the PBSP and the PBMC agreed with the diagnoses of IED and personality change due to head injury, the full psychiatric evaluation had found different diagnoses – intermittent explosive disorder, provisional diagnosis of post traumatic stress disorder and personality disorder not otherwise specified with dependent and passive aggressive traits. Taken as a whole, the PBMC appointments illustrated several persistent clinical/administrative shortcomings which were: 1. The lack of a database or other process to track and reconcile diagnoses meant that	

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		different parts of the clinical record – including those that were key to the day-to-day work of the clinicians who participated in the PBMC – contained different diagnoses. During clinical chart reviews the Monitoring Teams also noted that several individuals seen during the PBMC had unresolved r/o diagnoses in their diagnostic evaluations. Examples were Individuals #17, #77, #199, and #404. There was no discussion in the PBMC of the need to resolve the outstanding "r/o" diagnoses. 2. The box designated for tracking symptom targeted by medications was not used in a consistent manner. Sometimes specific psychiatric symptoms connected to the medication were listed, but other times target behaviors were listed that were relevant to the overall behavioral program but not to the medication. 3. Entries into the box designated for symptoms targeted by medications did not distinguish between symptoms and behavioral characteristics that would be tracked via anecdotal information and psychiatrist's examination, from symptoms that would be formally tracked by psychology to determine treatment response. 4. In many cases, psychology had not yet determined the psychiatric symptoms that would be monitored to assess whether or not particular medication treatments were effective, and graphs that would have reflected clinical response over time were not provided. 5. PBSP and PBMC templates for medication information were different, although the information required for both was the same. In several cases (e.g. Individuals #9 and #17), this may be the source of confusion regarding why the medicine was prescribed. 6. Difficulties in the coordination of psychiatric and neurological care resulted from lack of clarity about whether or not anticonvulsants were prescribed for behavioral and neurological care (e.g. Individual #17, #404, and # 613). 7. Medication plans described in provision J13 had not been developed and necessary parameters were not tracked. The Monitoring Team's assessment of compliance for Provision J3 included a determination of whether individuals prescribed psychotropic medications had an active treatment program. During the tour the Monitoring Team reviewed a total of 37 clinical records of individuals who were prescribed psychotropic medications. These were Individuals #9, #17, #29, #70, #76, #77, #91, #101, #195, #199, #212, #252, #267, #273, #315, #346, #353, #364, #404, #415, #429, #439, #447, #455, #456, #499, #513, #523, #531, #568, #596, #613, #636 #645, #714, #771, and #800. Each of these individuals had an active treatment program that was described in the individual's PBSP and PSP. In no case was there evidence that psychotropic medications were used for the convenience of staff, and there was no evidence that medication was used as punishment. The clinical records also showed that there was integration of psychiatric services with psychology, nursing, and medical services, to avoid prohibited uses. This was achieved through active engagement of the various disciplines in the psychiatric clinics, by the	

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		attendance of the staff psychiatrist in medical department activities and "morning report," by participation of the psychiatrist in integrated care meetings (one of which was attended by the Monitoring Team on 05/04/11), by participation of the staff psychiatrist in PSPs and other PSP activities, and by participation of psychiatry and psychology in facility wide polypharmacy reviews. The 37 clinical records were also reviewed for the presence of a master problem list. In all cases, clinical records included an Active Treatment List (APL). The APL typically included as a section of the individual's annual medical evaluation, and the APL was also filed as a separate item in the clinical record, immediately following the medical evaluation. The APL typically listed the psychiatric diagnoses that were listed in PBSP. Sometimes, however, the APL also listed non-DSM psychiatric diagnoses that were not found elsewhere in the clinical records. For example, the APL for Individual #91 included "Organic Personality Disorder," the APL for Individual #195 included "Mental Disorder due to Organic Brain," and the APL for Individual #596 included "Organic Personality with hyperactivity. " The term "organic" was not included in DSM IV, and the above diagnoses appear to have been retained from earlier diagnostic classifications. The APL for Individual #9 included "Neurotic Excoriation." In that case the error was also included in the PBSP. The Monitoring Team assessed whether or not clinical meetings reflected active member participation and whether meetings reflected data-based decisions. The Monitoring Team assessed this by observations made during the PBMC on 05-03 and by review of PBMC meeting records for 26 individuals who were seen in PBMCs during the first half of 2011. These were Individuals #9, #29, #70, #76, #101, #195, #212, #252, #267, #273, #315, #353, #364, #429, #439, #447, #455, #456, #499, #513, #523, #531, #645, #714, #771, and #800. The observations and documents showed that there was active member participation. Data based decisions were limited, since there was no formal tracking of psychiatric symptoms linked to the medications. In summary, the Monitoring Team review of psychotropic medication use at the Facility found that there was an active clinical process that was conducted by highly qualified and dedicated professionals. RSSLC professionals aimed for the highest clinical standards of care, and in many cases such care was provided. However, there was no system in place to determine or track agreed upon psychiatric diagnoses, there were no systems in place to record the reason(s) that psychotropic medications were prescribed, there was no system to identify or track the psychiatric symptoms that were targeted by psychotropic medications, and there were no systems for formal collection of behavioral data that would help assess whether or not the treatment was effective. The lack of such systems undermined the efforts of RSSLC professional staff to provide the best clinical care that was possible.	

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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, oral pre-treatment sedation was given for dental procedures 201 times and for medical procedures 120 times. TIVA was used 31 times. The Monitoring Team met with Mr. Ambrose Banor, RN Case Manager, to review procedures to assure safety during the procedures. For oral pretreatment procedures, Mr. Banor reviewed the use of a medical monitoring form. Instructions on this form included the following: *"The RN will complete an initial assessment of the individual. Based on the severity of the symptom, the RN will determine the type of care necessary. The RN/LVN will notify the Home Supervisor of the need for a direct contact staff to be assigned to provide care and a closer level of monitoring. The Nurse will in-service the Home Supervisor and direct contact staff on symptoms of illness, frequency monitoring and instructions for care".* DCPs were assigned to support individuals during procedures. In the case of dental appointments the individual was given the medication on the home unit, transported by wheelchair to the infirmary/dental clinic, and the DCP made an entry every hour on the condition of the individual. RNs or other medical professionals were notified if the individual appeared to need a higher level of attention. Vital signs were obtained at least once every eight hours, and monitoring continued for 24 hours. In the case of TIVA procedures, individuals were transported to the infirmary area at 6AM, to assure that per medical orders, the individual would not eat prior to the procedure. Medical safety was monitored by anesthesia staff during the procedure, and post anesthesia care was provided in the infirmary by facility nurse, in accordance with the *Acute Care Plan – Post Anesthesia Recovery.* Individuals remained in the infirmary; until REACT scores (a measure of level or alertness) reach a level of 8. Monitoring for safety continued on the residential unit for 72 hours. The Monitoring Team met on 05/04/11 with Drs. Heath and Eckenroth, and with Ms. Shelly Evan, Ms. Emma Wilsons, Mr. Larry Sanxter, and Ms. Lindsey Knott, all from the Behavioral Services Department. The meeting reviewed the current status of efforts to reduce the need to use pretreatment sedation for medical and dental procedures. At the time of the tour, dental support plans were in place for 238 individuals and full dental desensitization plans were in place for 26 individuals. Medical support plans were in place for 90 individuals and medical desensitization plans were in place for 18 individuals. Dental support plans, for example plans for tooth brushing or dental hygiene, were described to the Monitoring Team as essential steps toward eventual reduction in the need for sedation by the path of gradual acclimatization to dental needs, even if the individual was not ready for a fuller desensitization plan. The Monitoring Team selected for chart review 4 or 5 cases of oral pretreatment sedation for medical procedures, oral pretreatment for dental procedures, and cases of	Noncompliance

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		TIVA sedation. Documents reviewed are listed at the beginning of the psychiatry section of this report. Cases for medical procedures were selected by the Monitoring Team to provide a sampling of different types of medical procedures. Dental cases (TIVA and oral pretreatment sedation) were selected with no specific criteria for selection. Results were as follows: Medical pretreatment sedation: Individuals reviewed were #254 (10/14/10), #353 (01/03/11), #369 (11/10/10), and #399 (12/21/11). The Monitoring Team reviewed IPN and medical orders that confirmed that facility procedures for medical monitoring were followed. A medical support program was in place for Individual #369. The program plan was a 14 step procedure which consisted of the following: 1. Remains calm when told "you are going to the doctor." 2. Leaves the home to go the exam room 3. Gets in vehicle or goes in the right direction 4. Enters the building for the exam room 5. Enters waiting area 6. Sits in the waiting area for 1 minute 7. Follows staff into the Exam room 8. Stands until asked to sit on exam table or chair 9. Walks to the exam table or chair for 10 seconds 10. Sits on the Exam table or chair for 10 seconds 11. Allows medical staff to do visual exam 12. Allows medical staff to take vital signs or simulated procedure 13. Instruction and mental staff verbally praise (the individual) and immediately offer a desired edible or an individualized reinforcer 14. Upon completion of the trial the instructor will return (the individual) to ongoing programming site/living area. The Monitoring Team was provided with Medical Treatment Support Plan Data Record for weekly sessions on 04/18/11 and 04/25/11. The individual successfully completed all steps on the plan. Medical support plans were not received for Individuals # 254, #353, and #399. Dental pretreatment sedation: Individuals reviewed were #199 (10/04/10), #296 (03/28/10), #551 (10/25/10), #555 (11/01/10), and #598 (12/07/10). Medical monitoring was present for all individuals. Dental support plans were in place for Individuals # 199, #551, and #555, and #296. Individuals #199 and #555 had multistep dental support plans that were similar to Individual #369, described above. Individual # 551 had a dental support plan for tooth brushing. The plan was: 1. The instructor will assist (the Individual) to sit in a chair 2. Place towel on (the Individual)	

#	Provision	Assessment of Status	Compliance
		3. The instructor will explain to (the Individual) that they are going to brush teeth 4. The instructor will dampen the toothbrush with water from the faucet 5. The instructor will brush (the Individual's) teeth, once quadrant at a time 6. The instructor will praise (the Individual) during and after the tooth brushing is complete Data sheets for program implementation were provided for Individual #551, but not for the four other individuals for whom dental support plans were received. This suggested that there was a problem with the implementation of some programs. For Individual #598, no dental support plan was provided. TIVA: Individuals reviewed were #145 (11/15/10), #148 (12/09/10), # 207 (02/03/11), and #525 (11/16/10). Medical monitoring was confirmed for Individuals #148, #207, and #525. Information on medical monitoring was not provided for Individual #145. Individuals #145, # 148, and #207 had dental support plans for brushing, that were similar to the one described for individual #551 above. Data sheets were received for Individual #207, but not for Individuals #145 and #148. Individual #525 did not have a dental support plan. In the meeting on 5/4/11 the Monitoring Team commented to Facility staff that based on the discussions and descriptions provided to the Monitoring Team, the program to reduce pretreatment sedation through behavioral programming appeared strong, but that chart audits alone could fail to verify the strength of the behavioral programming. For example, Individuals #145, #148, and #207 all required TIVA sedation, but each had a behavioral program that addressed only basic oral hygiene, not their ability to participate in procedures in the dental clinic. However, the reason could well have been that each of the individuals was not ready for more than a basic oral hygiene program. The Monitoring Team encouraged the Facility to implement medical and dental support plans and to develop and implement assessments of intervention efficacy.	
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.	Dr. Ohiku was the lead psychiatrist. She worked on a full time basis, and her time was spent on responses to psychiatric crises, on elective psychiatric consultations, on follow-ups to acute cases, and on PBMC clinics. Dr. Ohiku attended PST clinics for individuals who received psychotropic medications, and she participated in routine planning meetings and administrative meetings. Drs. Hermant Patel and Dominic Joseph were contract psychiatrists who were primarily responsible for psychiatric evaluations. Each worked 8-10 hours per week. Dr. Rafael Guerrero was a contract psychiatrist who conducted PBMCs. Dr. Guerrero worked about 18 to 20 hours per month. The combined level of effort for the psychiatric group was about 63 hours per week, or 1.57 full time equivalents. The number of individuals supported by the psychiatrists was	Noncompliance

#	Provision	Assessment of Status	Compliance
		about 160. The overall caseload was about 100 individuals per FTE psychiatrist. This was an excessive caseload for the work at hand. The Facility had a vacancy for a full time psychiatrist and was recruiting for an individual to fill that position. This would return the Facility to full psychiatric staffing.	
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.	The evaluations of all three psychiatrists were very detailed, and they ranged in length from five to eleven single spaced pages. A wealth of clinical information was provided in the evaluations, and that information provided a necessary basis for future treatment plans for individuals. The evaluations were comprehensive, and the conclusions and recommendations were thoughtful and appropriate. The above notwithstanding, there were a number of areas where evaluations did not provide what was required by the settlement agreement. In particular: The SA Appendix B format for psychiatric evaluations contained 14 components, and the agreed upon tool used for the assessment of SA Section J compliance required that the individual's record should display every component in the format provided by Appendix B. Psychiatric evaluations done by Facility psychiatrists did not display the 14 components, even though the information required by the components was often found somewhere in the evaluation. As discussed under provision J2, Facility psychiatrists did not follow closely the requirement of Section 12 (XII) of the Appendix B format, to provide justification(s) for diagnoses. The requirements of the same component to resolve NOS and r/o diagnoses were also not met. Psychiatrists did not provide needed statements that would clarify why certain diagnoses were favored over others, when criteria for many diagnoses were met. In 14 of 37 clinical charts (37%) reviewed by the Monitoring Team, there were discrepancies between the diagnoses listed in the Appendix B evaluation and psychiatric diagnoses listed in other sections of the clinical record, for example the PBSP, the PBMC, the APL, or the pharmacy database. The discrepancies were for Individuals #17, #77, #91, #101, #346, # 404, #415, #429, #455, #456, #596, #613, #636, and #645. For completeness, in the 37 clinical records reviewed, the Monitoring Team found additional discrepancies in clinical records that did not involve the Appendix B evaluations. These were the clinical records for Individuals #9, #195, #252, #273, #513, and #800.	Noncompliance
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	The Facility completed Reiss Screen on 379 individuals who lived at the Facility. The Facility reported 12 admissions since 03/15/10. All but one of these individuals had received a Reiss screen. That individual (#573) had received a full psychiatric evaluation. The Facility reported no case of a positive Reiss screen on an individual living at the Facility who was not already receiving psychiatric services.	Noncompliance

#	Provision	Assessment of Status	Compliance
	Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	Compliance with this provision required review of the timeline for assessment of new patients. There were six admissions to the Facility since the last tour of the Monitoring Team. Reiss Screens were done for Individuals #128, #210, #361, #511 and #711. A Reiss Screen was not done for Individual #573. Individuals #128, #210, #361, #573 and #711 received psychiatric care and had comprehensive evaluations. Individual #511 did not need acute psychiatric care. Compliance with this provision also required psychiatric evaluations and diagnosis for all individuals who had a psychiatric diagnosis or who received psychotropic medication. This had not yet been done for all individuals who required evaluations. A process to provide comprehensive psychiatric assessment to all individuals who receive psychotropic medication was underway but had not been completed.	
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.	Several systems were in place at the Facility to integrate medication treatments with behavioral and other interventions. The primary place where integration took place was the PBMC clinic. Each individual was reviewed every three months, and many individuals were reviewed monthly. PBMC reviews were attended by the clinical pharmacologist and senior behavior analyst, by the individual's behavior analyst, nurse case manager, social worker, QMRP, and direct care professionals. The staff psychiatrist attended PST and PSP meetings and planning meetings, neurology clinics, and morning medical meetings. The staff psychiatrist led or participated in a number of facility wide committees that facilitated integration of pharmacological treatments with other disciplines and treatment modalities, for the Facility polypharmacy committee. During the tour the Monitoring Team assessed processes of collaboration through meetings with several psychologists, with a nurse case manager, and with the clinical pharmacist. Clinical collaboration between the disciplines was typically good, and this was evident during the PBMC attended by the Monitoring Team. The Monitoring Team had some concerns about integration of care, as follows: • <u>Clinical Issues:</u> The Monitoring Team assessed integration of care during the PBMC, on 05/03, and during the Integrated Clinical Meeting on 05/04, and by review of many PBSPs. In each case there was input and information from the various behavioral treatment professions such as psychology and psychiatry, but there was little effort to combine the information into a unified understanding of the individual being assessed and his/her needs. As a result, behavioral health care assessments and case formulations remained largely multidisciplinary, and	Noncompliance

#	Provision	Assessment of Status	Compliance
		not interdisciplinary. Many individuals who received pharmacological treatments were "dually diagnosed." Some of their behavioral symptoms could be best understood as "target" or challenging behaviors that reflected learned behaviors. Other behavioral symptoms defied functional analysis and the behavioral symptoms were better understood as reflections of psychiatric illness, or other etiologies such as medical illness, speech/language issues or sensory integration issues. For many individuals, the best clinical practice was to conduct case conferences to explore these issues and then to assign (per provision J9) appropriate modalities of treatment. At core, such a discussion would be a process similar to the PSP, but more narrowly conducted within the realms of behavioral healthcare. At the time of the compliance tour, this function was filled most often through discussions in the PBMC, but that was already a very busy venue. The PBMC setting could be used for broader case conferencing provided that appropriate time was set aside, perhaps at a different time than the individual's routine clinical reviews. • Clinical/Administrative Issues: The Monitoring Team had concerns that the work products generated in settings like the PBMC were not properly incorporated into the individual's clinical records. The absence of a common diagnostic database and the lack of a system to record why medications were prescribed and how their efficacy would be addressed was discussed under provisions J2 and J3. Similarly, the PBSP format used at the Facility did not provide a place for the information required for new medication plans (J13) to be incorporated into the PBSP. That information was necessary for integrated care, and inclusion of the information in the PBSP was required by DADS Policy 008. Additionally, it was not clear to Monitoring Team where needed interdisciplinary formulations could be recorded in the clinical record in a manner that they would be and retained over time. The PBSP could be used for such recording, but the current formatting would have needed to be modified. Annual psychiatric updates are in use elsewhere in the DADS system, but not at RSSLC. As a general matter the Monitoring Team found that integrated and interdisciplinary care could be provided only when clinicians from various disciplines were able to access the information they needed, when they needed it. Systems were not in place to do so.	
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,	All individuals reviewed by the Monitoring Team and who received psychiatric medications had a PBSP. All individuals identified by the PST as appropriately served through the use of psychotropic medication also had non - pharmacological treatments as required by this provision. All PBSPs reviewed contained language that stated that less intrusive interventions had been tried.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 provision also required that the PST should determine whether individuals were best served through medication treatment, behavioral treatments, or other interventions, in combination or alone. This determination was required before a PBSP was put in place. In the Plan of Improvement (POI) the Facility indicated that these functions were determined through PBMC and PST meetings, and during routine planning meetings. However, if these discussions took place they were not documented, and the Monitoring Team could not determine how the selections were made. PBSPs did not have a developed psychotropic medication section that could have clarified the choice of medication treatments for some individuals.	
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.	During the tour, the Monitoring Team confirmed with the staff psychiatrist that discussions about medication related risks and about alternative treatments took place at the time a new medication was proposed, typically during a PBMC. PBMC participants at the Facility included the psychiatrist and nurse, but not the primary care physician. The staff psychiatrist clarified that discussions with the PCP did take place, for example during the medical morning meetings. The Monitoring Team reviewed the ten most recent medications started by Facility psychiatrists. The medications were for Individuals #91, #199, #273, #415, #455, #499, #568, #596, and #636 (one of the individuals had two new medications). . The Monitoring Team reviewed the documentation provided for the psychotropic medications proposed for these individuals, but could not locate documentation of discussions about alternative treatments during PBMCs, or documentation of subsequent discussion with PCPs. The Monitoring Team does not doubt that the needed discussion took place, but the Facility must develop a process under which this and other requirements related to proposed new medication treatment will be completed and documented. The requirements for new medications are outlined in Provisions J.10, J.13, and J.14.	Noncompliance
J11	Commencing within six months of the Effective Date hereof and with	Individuals who were treated with polypharmacy were scheduled for PBMC review every month. Review of polypharmacy at the PBMC was detailed. Psychotropic medications	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	were listed, laboratory and pharmacy information was reviewed by the clinical pharmacist, and side effect scales were reviewed by the RN. In addition, RSSLC has put in place a facility- level tracking for polypharmacy. The facility polypharmacy committee met during the tour and the Monitoring Team attended the meeting. The clinical pharmacist provided committee members and the Monitoring Team with a list of 50 individuals identified with psychiatric polypharmacy	
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 Facility provided the Monitoring Team with a list of all individuals reviewed with MOSES and DISCUS examinations. Review of side effect screening was confirmed via chart review and participation in the PBMC. At the time of the last compliance tour the Monitoring Team recommended that treating psychiatrists should review and sign quarterly drug regimen reviews (QDRR) and DISCUS evaluations. Both treating psychiatrists had begun doing so. The Monitoring Team confirmed this practice via review of clinical records and observation of a PBMC. The Monitoring Team had also recommended that the facility should develop a list of individuals who have been found on the basis of DISCUS screenings to have tardive dyskinesia. The Facility provided the Monitoring Team with such a list. All of this is positive and moves the Facility close to compliance with this provision. However, when the Facility was asked for a list of all individuals who underwent a recent addition or discontinuation of a neuroleptic medication, as well as all individuals who had a dose change of their neuroleptic, along with 12 months of DISCUS and MOSES reportsthe Facility responded by indicating that they "do not keep records on new antipsychotics started" but provided a hand written list of such medication changes. Unfortunately, associated DISCUS and MOSES assessments were not provided to the Monitoring Team for review. Without tracking of additions and discontinuations of neuroleptic medications, the Facility misses a useful way to determine that assessment for TD is done not only quarterly, but also "as needed" as required by this provision.	Noncompliance
J13	Commencing within six months of	In order to review implementation of the medication treatment plan requirements, the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Monitoring Team reviewed the ten most recent medications started by Facility psychiatrists. These were medications for Individuals #91, #199, #273, #415, #455, #499, #568, #596, and #636 (one of the individuals had two new medications). None of these individuals had the medication plans described in the provision. As a result, information submitted to the HRC and the LAR did not contain basic information about the why the medication was proposed and how its effects would be assessed. Instead, the forms contained standard language drawn from the overall behavioral program. Examples were: • Individual #199: On 03- 23-11 the psychiatrist wrote a detailed IPN note that documented that the individual had previously been treated with success with lithium, and the psychiatrist noted that the medication had been helpful in the treatment of severe depression. The psychiatrist identified the symptoms and behavioral characteristics of the depression as withdrawal and inability to function, to the point that the individual became overtly psychotic and indiscriminately aggressive. Her hope was that the medication would alleviate those symptoms. However, the informed consent form given to the LAR listed lithium along with three other medications, and stated the expected benefits of "the medications" would be the " elimination or reduction in rates of aggression to others, aggression to environment, verbal aggression, non compliance, work program programming refusal and pouring liquids and replacement with socially acceptable and adaptive behaviors, improved learning of new skills, increased participation in scheduled treatment programs and leisure activities, and access to less restrictive settings." • Individual #499 was described by the psychiatrist as having a mood disorder, characterized by depression, agitation, social withdrawal, anxiety, poor sleep and self injury. Zoloft was proposed as a treatment for those symptoms. In the consent for medication provided to the LAR, however, only self injury was listed. • Individual #568 was diagnosed with bipolar disorder and was described by the psychiatrist as having mood lability, pacing, high energy, irritability and stripping. Seroquel was proposed as a treatment. But in the informed consent form, only aggression and stripping were mentioned. Absence of the medication plans required by this provision also prevented needed integration of information about psychotropic medications with other aspects of behavioral healthcare. For example, DADS Policy 008 (Psychological and Behavioral Services) required that the information on medication that was listed in the language of this provision should be included in each individual's PBSP. PBSPs for 37 individuals were examined as part of the Monitoring Team's clinical chart reviews. None of the PBSPs contained the required information.	

#	Provision	Assessment of Status	Compliance
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Informed consent forms for the ten most recent medications were reviewed. In all cases informed consent was obtained in a timely fashion. However, the expectations of the Monitoring Team were that the consents should show that adequate information was provided to the LAR about diagnosis, purpose of the medication, expected benefits and side effects. Side effects were listed in all cases. As described in the three examples provided for provision J13, in many cases, the description of the purpose of the medication and expected benefits were not the same as were described by the psychiatrist in the PBMC or IPNs. Instead, the consent listed some aspects of the psychiatric care, along with a (re)statement of the plan for overall behavioral programming. Therefore, the information provided to the individual or LAR was either inaccurate or incomplete, and consent cannot be considered to be informed.	Noncompliance
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	The staff psychiatrist attended the neurology clinic, and that facilitated coordination of psychiatric and neurological care. During the PBMC the staff psychiatrist showed attention to neurological issues and on several cases identified neurological concerns that she planned to discuss with the neurologist at the next clinic. However, cases reviewed by the Monitoring Team during the tour, showed a continued need to clarify whether medications are prescribed for neurological illness, for psychiatric purposes or for both. For example, Individual #17 was prescribed, anticonvulsants, but it was not clear whether these medications were for both seizures and behavior or for seizures alone. Improved coordination between psychiatry and neurology was also needed for individuals like Individual #404. In the case of that individual it was clear that the anticonvulsant medication (Keppra) was prescribed for seizures and not for behavior. However, as evidenced by the Monitoring Team during the PBMC on 05-03-11, the PST team had information that suggested that the individual might not have an active seizure disorder, and there was concern that Keppra might be worsening the individual's irritability/anxiety. Such issues are best addressed and resolved by direct conversations between the psychiatrist and neurologist.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Psychiatrists should review the psychiatric diagnoses located in various sections of individuals' clinical records, to resolve any differences between these diagnoses and to resolve outstanding "R/O" and "NOS" diagnoses. For each individual, the resulting agreed-upon diagnoses should be accompanied by a brief statement that will provide needed justification(s) for the diagnoses, and the statement should list appropriate

symptoms/behavioral characteristics of the diagnoses. If psychiatrists conclude that there is no viable clinical alternative to the use of an "NOS" diagnosis (for example in some cases where the diagnosis of developmental disorder NOS may be needed), an explanation should be provided.

2. There should be a system to maintain a record of the agreed -upon psychiatric diagnoses, and only those diagnoses should be cited in the various sections of the clinical record. The Facility should determine how diagnoses should be updated and by whom. For example, psychologists might take the lead for determinations of Axis II diagnoses of the degree of intellectual disability, and possibly some Axis I diagnoses such as pica as well.
3. There should be a system to document the reason(s) that each psychotropic medication is prescribed, and each medication should be linked to at least one symptom or behavioral characteristic of a psychiatric disorder diagnosed for the individual in question.
4. The Departments of Psychology and Psychiatry should clarify how combined assessments and case formulations are conducted, and how the results are used to recommend one or more modalities of behavioral health care treatment (behavioral treatment, medication treatment, or other treatment modalities).
5. Psychologists should provide formal behavioral tracking of at least at least one psychiatric symptom or behavioral characteristic associated with each psychotropic medication. Data (preferably including a graphic presentation), should be provided during PBMCs, and should be included in PBSPs.
6. Medication treatment plans, as described in SA provision J13, should be developed for all new and existing medication treatments.
7. Since PCPs do not participate in PBMCs, there should be a mechanism to document their participation of deliberations about new medications, in particular as related to risk/benefit deliberations and consideration of treatment alternatives.
8. Informed consents for medications and presentations to the HRC should be based on the information provided in the medication treatment plans.
9. There should be a mechanism for treating psychiatrists to provide periodic updates regarding the overall status of psychiatric treatment.
10. A representative of the Department of Psychiatry should participate in conferences that follow the use of more than three episodes of restraint in 30 days.
11. There should be a QA/QE component in the campus-wide program to minimize the need for pretreatment sedation
12. Psychiatric evaluations should follow the 14 components of the evaluation outlined in Appendix B of the SA.
13. Medical and dental support plans to reduce the need for pretreatment sedation should be implemented and data sheets completed.
14. There should be measures to assess effectiveness of efforts to reduce the need for pretreatment sedation.
15. The Departments of Psychology and Psychiatry should clarify where in the admission process and the annual review process the discussion about whether an individual is best supported by behavioral, pharmacological, or other interventions, in combination or alone, takes place, and how that that discussion is documented.

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. RSSLC Plan of Improvement (POI) 4/18/11 2. Facility Policies and Procedures - (J.6 – 03/15/2011) 3. Minutes for the Behavior Services Peer Review Committee (PRC) meetings – Oct 2010 through March 2011 4. Preliminary materials for Competency-Based Training. 5. Annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), 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 included the following individuals:#52, #86, #91, #112, #146, #156, #162, #174, #200, #253, #267, #429, #455, #531, #552, #561, #583, #618, #630, #708, and #758 **People Interviewed:** 1. William Eckenroth, PhD – Director of Behavioral Services 2. Elizabeth Ohiku,MD – Lead Psychiatrist 3. Cynthia Fannin – Director of Education and Training 4. Carol Agu – QMRP Coordinator 5. Heather Blackwell – Director of Vocational Services 6. Candice Mays, MA – Associate Psychologist 7. Emma Williams, MA – Associate Psychologist 8. Billie Dejean, MA, BCBA – Associate Psychologist 9. David Savage, Program Auditor **Meetings Attended/Observations:** 1. Active Treatment Meeting – 5/3/2011 2. Psychiatric Clinic – 5/3/2011 3. At Risk Team Meetings for Individuals #363 and #385 4. PSP for Individual #200 – 5/3/2011 5. PSP for Individual #52 – 5/3/2011 6. Consumer Report Observation interviews – Vocational, Forever Young and Day Program on 5/5/2011 7. Observed training, active treatment, staff interaction and meals at the following residences and programs: Angelina, Colorado, Neches, Trinity, Leon, Sabine, and San Jacinto.
	Facility Self-Assessment: The Facility indicated that Provision K2 of the Settlement Agreement had met the criteria for substantial compliance. The Monitoring Team agreed with this assessment. The Facility indicated that progress had been made in training Behavior Services staff and increasing the number of staff who possessed or were working toward the BCBA credential. The Monitoring Team agreed that progress was evident, but did not

	note progress sufficient for substantial compliance.
	Summary of Monitor's Assessment: Observations, interviews and record reviews were conducted on-site at RSSLC from 5/2/2011 through 5/6/2011. Record reviews continued off-site for several days following the site visit. Based upon the information gathered, one Provision of the settlement Agreement was determined to be in substantial compliance; K2. In several areas addressed by the Settlement Agreement, RSSLC failed to demonstrate that significant effort had been invested toward compliance with the Settlement Agreement. The timeframes for four Provisions, K3, K5, K6, and K7, had been exceeded without significant progress having been achieved by the Facility. Three additional Provisions, K4, K10, and K12, had time remaining within which compliance could be achieved. The lack of progress by the Facility thus far in relation to these three Provisions, however, made compliance within the specified timeframes much more difficult. One area of particular concern was the collection and presentation of treatment data. RSSLC had not addressed weaknesses in the data collection and graphing procedures that had first been noted during the baseline visit. The "DRA Data Sheet" remained the sole tool for collecting data even though this tool is not appropriate for many topographies and frequencies of treatment targets. Data graphs continued to present data only as mean daily displays even though this format was not appropriate for many types of target parameters such as severity and behaviors that are presented in bursts. The assessment of behavior, intellectual ability, adaptive ability, and mental illness also continued to reflect the same weaknesses noted during the baseline site visit. No progress had been achieved in regard to timely assessment of intellectual and adaptive skills. Although there was expanded use of anecdotal assessments of behavior functions and preference assessments, there was a continued lack of sophistication and expertise noted in the assessment of behavior. As a result, an adequate understanding of undesired behavior was not achieved for individuals living at the Facility, substantially reducing the probability of successful behavior change efforts. Similarly, there was no indication that effort had been made to ensure the integration of behavior and mental illness into a single case formulation and approach to treatment. Behavior interventions were only minimally improved over baseline measures. Many PBSPs continued to include intervention strategies that were not supported by the available assessments. Instructions to staff lacked specificity and substantially reduced the probability of consistent implementation. Baseline or comparison data were typically several years old or unrelated to current circumstances, preventing the determination of efficacy for PBSPs.Only 11% of the PBSPs reviewed during the site visit included baseline or comparison data sufficient to assess changes in behavior. In many instances, the comparative data were collected several years prior to the development of the current PBSP It was noted that limitations in protecting individuals who lived at the Facility from unnecessary risk also continued. In several cases, timeframes for consent and approval of behavior treatment plans had not been met. There also were found to be several individuals for whom PBSPs to address potentially harmful

	behavior were unsuccessful and yet had not been reviewed or revised in several months. Based upon the information gained during the site visit, there was little evidence that RSSLC had attempted to comply with Section K of the Settlement Agreement in a coherent, consistent and timely manner. Substantial changes will be necessary for the Facility to achieve progress and meet the timeframes for substantial compliance with the Settlement Agreement. **For Provision K.1:** This Provision was determined not to be in compliance. Although the Facility had increased the number of BCBAs, one quarter of the Behavior Services department was not involved in any formal training in applied behavior analysis. **For Provision K.2:** This Provision was determined to be in compliance.Dr. Eckenroth had extensive experience in the field of intellectual and developmental disabilities, and was board certified in applied behavior analysis. **For Provision K.3:** This Provision was determined not to be in compliance.No documentation of the PBSP review process was provided by the Facility. **For Provision K.4:** This Provision was determined not to be in compliance.RSSLC had not addressed weaknesses in the data collection and graphing procedures that had first been noted during the baseline visit, such as the use of DRA sheets as the sole data collection tool. **For Provision K.5:** This Provision was determined not to be in compliance. No testing of intellectual or adaptive ability was conducted at the Facility. Behavior assessments lacked sophistication. There was no indication of an integrated process for assessing and treating behavior and mental illness. **For Provision K.6:** This Provision was determined not to be in compliance. Based upon the information presented in K5, minimal documentation in the record reflected assessment findings that were demonstrated to be current, accurate, or complete. **For Provision K.7:** This Provision was determined not to be in compliance. 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. No treatment plans were developed for the 17 individuals involved in psychological services other than PBSPs.

	For Provision K.9: This Provision was determined not to be in compliance. Many PBSPs continued to include intervention strategies that were not supported by the available assessments. Instructions to staff lacked specificity and substantially reduced the probability of consistent implementation. Baseline or comparison data were typically several years old or unrelated to current circumstances, preventing the determination of efficacy for PBSPs. **For Provision K.10:** This Provision was determined not to be in compliance. Data graphs lacked condition change lines, condition labels or indication of changes in treatment or environmental conditions. **For Provision K.11:** This Provision was determined not to be in compliance. The average Flesch Reading Ease score for the PBSPs was 68.43, with a range of 59.4 to 81.4. The average Flesch-Kincaid Grade Level for the PBSPs was 7.53, with a range of 5.1 to 8.6. This indicates the PBSPs were readable. However, instructions to staff lacked specificity and substantially reduced the probability of consistent implementation. **For Provision K.12:** This Provision was determined not to be in compliance. At the time of the current site visit, a system for assessing staff competence and providing competence-based training for DCP staff had just been implemented by the Behavior Services department. **For Provision K.13:** This Provision was determined not to be in compliance. Four BCBAs for 384 individuals residing at 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,	During the previous site visit, it was noted that Behavior Services department at RSSLC had achieved progress toward the development of demonstrably competent staff. Specifically, RSSLC had one employee with board certification and 11 more staff who were either participating in or who had completed BCBA classes. During the current site visit, documentation reflected that the Facility continued to make progress in this area. The number of BCBA credentialed staff employed by the Facility had increased to four. In addition, 15 staff members were enrolled in or had completed the training courses. It was disconcerting, however, that 25% of the Behavior Services staff were not participating in any training related to board certification in applied behavior analysis.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>
<table>
<tr><td></td><td>10/2010</td><td>5/2011</td><td>Change</td></tr>
<tr><td>Total number of BCBAs</td><td>1 (5%)</td><td>4 (20%)</td><td>15%</td></tr>
<tr><td>Total staff enrolled in/completed BCBA classes</td><td>11 (55%)</td><td>15 (75%)</td><td>20%</td></tr>
</table>

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 PBSPs generally could not be considered as having promoted the growth, development, and independence; minimized regression and loss of skills; and ensured reasonable safety, security, and freedom from undue use of restraint.</td><td></td></tr>
<tr><td>K2</td><td>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.</td><td>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, and had earned board certification in applied behavior analysis. Dr. Eckenroth's experience and credentialing satisfied the requirements of this provision.</td><td>Substantial Compliance</td></tr>
<tr><td>K3</td><td>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.</td><td>The role of the peer review committee has been briefly defined 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</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		structure and a true peer review process. Discussion consisted primarily of a clerical review of documents, and committee members evidenced a general lack of familiarity with basic applied behavior analysis. At that time, no committee members were board certified behavior analysts. During the site visit in October of 2010, it was noted that some changes had been implemented, but there was little evidence to support a substantial improvement in the peer review process at RSSLC. At the time of the October 2010 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. During the current site visit, it was reported that the peer review process had again been revised. On April 1, 2011, the Facility had dissolved the internal Peer Review Committee. In place of the Peer Review Committee, the Facility had opted to require all PBSPs to be reviewed by the BCBA supervisor of the author of the intervention plan. Once approved by the BCBA supervisor, PBSPs were then forwarded to the Behavior Therapy Committee for a multidisciplinary review. No documentation produced by the PBSP review process was provided by the Facility at the time of the current site visit. It was therefore not possible to ascertain the quality of the review or the results of the review process. An examination of PBSP reviews conducted by Facility BCBAs, however, did suggest an inconsistency in the ability of the Facility to provide adequate peer review. For Individual #91, a review by a RSSLC BCBA was conducted on 3/21/2011. The review produced these recommendations. • Complete the information in the med table • Specify the number of ABC observation sessions, the length of the sessions, and where those sessions occurred. A review conducted of this same assessment and PBSP by the Monitoring Team during the current site visit revealed several additional weaknesses that had not been identified during peer review. • The ABC observational assessment had identified four antecedents and did not indicate a primary or most common antecedent. An administration of the Questions About Behavior Function (QABF), a widely used, anecdotal assessment, indicated escape as the primary function. Although anecdotal assessments, such as the QABF, can provide valuable information about behavior and functions of behavior, there is a need for agreement between anecdotal	

#	Provision	Assessment of Status	Compliance
		assessments and information gathered through more objective procedures such as direct observation. In regard to Individual #91, the conclusion was formed that escape was the primary function without addressing the lack of agreement between anecdotal and direct observation data. • The PBSP included frequency counts as a measure of delusions and hallucinations even though both are typically conditions that exist for long durations and can fluctuate in severity. • Individual #91 had been prescribed two new psychotropic medications during the time of the peer review, and had been hospitalized for Deep Vein Thrombosis. None of these factors were included in the behavior assessment. For Individual #630, a RSSLC BCBA astutely offered the following recommendations. • Add information regarding ABC observations and preference assessments. • Revise the restraint release criterion. • Obtain approval from the physician for contingent restraint. A review conducted of this same assessment and PBSP by the Monitoring Team during the current site visit revealed several additional weaknesses that had not been identified during peer review. • There were no baseline data for the selected replacement behaviors. • Baseline data for the target behaviors were collected no more recently than 2008. • The PBSP did not include specific instructions for data collection. • The PBSP did not include specific criteria, such as behavior measures and time frames, to allow for the determination that the intervention was not successful and in need of revision. 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 intellectual and developmental disabilities. During the site visit, there were no indications that an external peer review process was in place at the Facility. Without an accurate and consistent approach to peer review, RSSLC will continue to experience difficulty in demonstrating that a peer-based system to review the quality of PBSPs has been established. As compliance with this Provision is required within 12 months of the Settlement Agreement, documentation reflected that RSSLC had failed to comply with this Provision.	
K4	Commencing within six months of the Effective Date hereof and with	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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>benefit from behavioral or psychopharmacological interventions. At that site visit, in 24 out of 24 records reviewed, data collection consisted of narrative documentation of circumstances surrounding the display of an undesired behavior. The status of data collection practices remained essentially unchanged during the October, 2010 site visit.

During the current site visit, it was obvious that RSSLC had implemented minimal changes to the data collection process. Observations and record reviews reflected the lack of change in data collection practices.

<table>
<tr><th></th><th>10/2010</th><th>5/2011</th><th>Change</th></tr>
<tr><td>Data collection utilized methods other than the DRA Sheets to document behavior displays.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Documentation of attempts to collect interobserver agreement on treatment data.</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>

The data system needs to be more sensitive to each individual's needs. That is, in addition to providing an efficient means for the DCPs to collect data, the data system needs to be able to assess both behaviors that occur at low rates, as well as behaviors that occur at very high rates (e.g., stereotypic behavior, undesirable verbal behavior, etc.) with accuracy. 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 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 18 of 18 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 18 of 18 records (100%), treatment objectives were stated in terms of total frequency while data were presented as daily mean frequency per week.
• In 18 of 18 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 #618 included three data graphs with three different Y-axis maximum values (.04, .14, and .40). In order to allow comparisons of different measures on</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		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 three of 18 records (17%), the maximum value of the Y-axis changed from one month to the next. This can lead to misinterpretation when comparing data month to month. • In 18 of 18 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. • In seven of 18 records (39%), the graph legend covered a substantial portion of the data points and data path on the graph. By blocking the data points from view, the ability to determine intervention response was substantially impaired. Due to 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. As a result, evidence-based decisions regarding treatment were not routinely formed or even possible. This may have contributed to the lack of action to revise programs documented in the following examples: • For Individual#112, displays of aggression had been increasing over 4 months while other undesired behaviors declined. The progress review did not indicate whether this intervention was considered successful or in need of revision. • For Individual #156, aggression and other undesired behaviors increased over six months while no strengthening of replacement behavior was documented. For each of the six months, progress notes contained the recommendation to continue the PBSP. • For Individual #174, data on self-injury had not indicated a consistent response to treatment over the previous 12 months. A safety plan was implemented in September of 2010, but documentation did not reflect any changes to the PBSP. • For Individual #531, successful displays of replacement behavior had decreased for six months as self-injury was increasing. Documentation did not reflect a review of the behavior assessment or intervention strategy. The continued lack of revision to inadequate data collection and presentation practices will continue to be a substantial impediment for RSSLC in making progress toward compliance with this portion of the Settlement Agreement.	
K5	Commencing within six months of	Intellectual and adaptive testing results play an integral role in understanding an	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>individual. While a functional assessment may provide vital information regarding a single behavior or functional class of behaviors, intellectual and adaptive testing provides insight into the current cognitive and adaptive abilities of the individual. Such testing can identify essential skills or behaviors the individual has not mastered, and provide a framework for the development of skill acquisition training programs. 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.

Information in the table below reflects that no progress was achieved by RSSLC in integrating adaptive and intellectual testing into the psychological assessment process.

<table>
<tr><th></th><th>10/2010</th><th>5/2011</th><th>Change</th></tr>
<tr><td>Psychological Assessments contained findings from an intellectual test administered within the previous five years.</td><td>Zero of 17 (0%)</td><td>Zero of 18 (0%)</td><td>0%</td></tr>
<tr><td>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.</td><td>Zero of 17 (0%)</td><td>Zero of 18 (0%)</td><td>0%</td></tr>
<tr><td>Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.</td><td>Zero of 17 (0%)</td><td>Zero of 18 (0%)</td><td>0%</td></tr>
<tr><td>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.</td><td>Zero of 17 (0%)</td><td>Zero of 18 (0%)</td><td>0%</td></tr>
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Specific examples of weaknesses in the integration of intellectual and adaptive</td><td></td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
assessment are presented below.

For Individual #429, the most recent intellectual and adaptive testing was completed in 1988.
For Individual #455, the most recent intellectual and adaptive testing was completed in 2002.
For Individual #583, the most recent intellectual test was completed in 1996. The most recent adaptive assessment was completed in 2000.

The assessment of behavioral function is an essential component of effective behavior change and requires 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 a series of ambiguous statements regarding the function of the undesired behavior. Rather, the product of the assessment process is a specific statement regarding the most likely function of the behavior or an indication of how ambiguous findings will be resolved. Without additional investigation, ambiguous statements are indicative of an assessment process that has not been completed.

Information in the table below reflects the degree of progress achieved by RSSLC in enhancing the quality of functional assessments.
<table>
<tr><th></th><th>10/2010</th><th>5/2011</th><th>Change</th></tr>
<tr><td>A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis.</td><td>Zero of 17 (0%)</td><td>Four of 18 (22%)</td><td>22%</td></tr>
<tr><td>The process or tool utilizes both direct and indirect measures.</td><td>Zero of 17 (0%)</td><td>Four of 18 (22%)</td><td>22%</td></tr>
<tr><td>Identification of setting events and motivating operations relevant to the undesired behavior.</td><td>Zero of 17 (0%)</td><td>One of 18 (6%)</td><td>6%</td></tr>
<tr><td>Identification of antecedents relevant to the undesired behavior.</td><td>Zero of 17 (0%)</td><td>One of 18 (6%)</td><td>6%</td></tr>
<tr><td>Identification of consequences</td><td>Zero of 17 (0%)</td><td>One of 18 (6%)</td><td>6%</td></tr>
</table>
</td><td></td></tr>
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#	Provision	Assessment of Status				Compliance
		relevant to the undesired behavior.				
		Identification of functions relevant to the undesired behavior.	Zero of 17 (0%)	One of 18 (6%)	6%	
		Summary statement identifying the variable or variables maintaining the target behavior.	Zero of 17 (0%)	Two of 18 (11%)	11%	
		Identification of functionally equivalent replacement behaviors relevant to the undesired behavior.	Zero of 17 (0%)	One of 18 (6%)	6%	
		Identification of preferences and reinforcers.	Zero of 17 (0%)	Four of 18 (22%)	22%	

Specific examples of weaknesses in functional assessment are presented below.

- For Individual #86, the assessment indicated the functions of the undesired behavior to be a psychiatric disorder and escape; psychiatric disorder (although an issue to be discussed in terms of effects on behavior or potential role in affecting motivating operations) is not a function of a behavior. The replacement behavior identified by the assessment involved strengthening appropriate strategies for obtaining attention. If the identified function of escape was valid, obtaining attention would not constitute a replacement of the reinforcer maintaining the behavior.
- For Individual #174, results of the assessment process suggested several functions for the undesired behavior. Although the functional assessment report stated that a functional analysis, direct observations, and interviews were conducted, no information specifically from those procedures was reported. The narrative suggested more than one functional class, but no data or assessment results were provided to indicate if multiple functional classes were actually involved or if the conclusions of the assessment report were valid.
- For Individual #531, only a descriptive interview and an administration of the QABF were conducted. The interview indicated that the individual slept at night, but documentation in the chart reflected chronic sleep disturbance. A summary of the assessment findings included a statement that the individual's behavior was negatively reinforced by receiving attention. Receiving attention typically is considered to be positive reinforcer as, when attention is actually reinforcing, behavior is strengthened by the presentation of a stimulus rather than the removal of a stimulus.
- For Individual #758, the QABF was used to identify potential functions for three

#	Provision	Assessment of Status	Compliance

undesired behaviors. The results of the QABF were different for each of the three behaviors, but emphasized the involvement of escape as a function. Elsewhere in the assessment, it was indicated that the individual was motivated by attention. The PBSP emphasized increasing social skills and increasing opportunities for attention. The disparity between the results of the QABF and the indirect assessments was not addressed with additional assessments. Furthermore, the disparity between the intervention plan and the findings of the QABF was not addressed in the assessment or intervention plan.

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.

Ten of 18 records included in the sample 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 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.

	10/2010	5/2011	Change
Psychological Assessments included a scores from an instrument designed for the assessment of mental illness in people with intellectual and developmental disabilities.	11 of 11 (100%)	17 of 18 (94%)	-6%
Psychological Assessments integrated mental illness into the functional assessment process.	Zero of 11 (0%)	One of 10 (10%)	10%
The functional assessment	Zero of 17 (0%)	One of 10 (10%)	10%

#	Provision	Assessment of Status	Compliance

included differentiation between learned and biologically based behaviors.				
Psychological Assessments integrated mental illness assessments into the findings of the assessment report.	Zero of 11 (0%)	Zero of 18 (0%)	0%	

In the time since the baseline visit, RSSLC had demonstrated very little progress in the area of integrating learned behavior and mental illness into a coherent diagnostic case formulation. The only area of progress involved the addition of a rating scale to screen mental illness. During the baseline visit, it was documented that no individuals had been screened for mental illness. During the current site visit, nearly 100% of individuals had been screened for mental illness using the Reiss Screen for Maladaptive behavior.

Unfortunately, during the current site visit it was evident that almost no effort had been made by RSSLC toward integrating the findings of the mental illness screening, or any other assessment of mental illness, into the diagnostic and treatment planning process. Furthermore, although an interdependent relationship is often seen between symptoms of mental illness and learned behaviors, RSSLC had not initiated formal attempts to develop or implement a treatment planning process that integrated functional assessment of behavior with the assessment of psychopathology.

Because of the failure by RSSLC to integrate the assessment and treatment of behaviors and mental illness, individuals who lived at the facility were not provided with a coherent, effective, and safe intervention process.

- For Individual #86, the assessment indicated the functions of the undesired behavior to be a psychiatric disorder and escape; psychiatric disorder is not a function of a behavior. The replacement behavior identified by the assessment involved strengthening appropriate strategies for obtaining attention. If the identified function of escape was valid, obtaining attention would not constitute a replacement.
- Individual #91, who was diagnosed with dementia, was prescribed Namenda on 12/20/2010. Namenda is a NMDA receptor antagonist that is used to treat Alzheimer's disease, and may help a person to think more clearly and perform daily activities more easily. Shortly after being prescribed Namenda, the individual experienced increased "psychotic behaviors" and aggression toward others. No functional assessment of behavior or assessment of mental illness was conducted following the increase in undesired behaviors. The records reflected, however, that the individual had health problems, including Deep Vein

#	Provision	Assessment of Status	Compliance
		Thrombosis (DVT), which could have produced a change in behavior. In early February, the individual was prescribed Risperdal to address the problem behaviors. Risperdal is not approved for the treatment of dementia-related psychosis due to increased mortality risks. There was no indication in the submitted records that the potential causes of the undesired behavior had been evaluated or that alternative, less risky treatments had been considered. • For Individual #174, data on self-injury had not indicated a consistent response to treatment over the previous 12 months. A safety plan was implemented in September of 2010, but documentation did not reflect any changes to the PBSP. Psychiatric medications at the time of the compliance tour were Depakote 1500 mg daily and Concerta 18mg daily. The individual experienced episodes of restraint on 9/27/10, 10/11/10, 10/25/10, 10/27/10, 12/2,/10 12/26/10, 01/20/11, 02/19/11, and 2/21/11. No functional assessment or formal diagnostic formulation was conducted during this time. PST meetings took place on 10/19 and 10/28 to review restraint utilization. The notes taken were brief and suggested that psychiatric management was central to the treatment plan without further assessment and consideration of alternative behavior intervention strategies. An observation of a Psychiatric Clinic on 5/3/2011 also revealed weaknesses in the behavior/mental illness case formulation process. • The psychiatrist inquired about progress toward plans (discussed at the previous psychiatric clinic) to enhance data targets and collection for the individual being reviewed; both mood disorder and behavior were specifically mentioned by the psychiatrist. The psychologist responded by providing anecdotal information regarding behavior and did not discuss any changes to the data collection process. • When the psychiatrist specifically inquired about current treatment data, the psychologist responded by stating the number of restraint applications since the previous clinic and provided anecdotal information regarding those restraint applications. Following the information about restraint, the psychologist verbally presented data on treatment targets but did not supply any graphs for those targets. • The psychiatrist presented her opinion that current behavior difficulties were due to "mood elevation and paranoid delusions." Based upon this perception, the psychiatrist then indicated the intent to change both the psychiatric diagnosis and prescribed psychotropic medications. No formal assessment of symptoms or consideration of objective data was conducted. The Settlement Agreement requires full compliance with this provision within 18	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>months. Based upon documentation available to the Monitoring Team at the current site visit, there was little evidence to support that RSSLC had made a coherent and serious effort to comply with this provision of the Settlement Agreement.</td><td></td></tr>
<tr><td>K6</td><td>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.</td><td>Based upon the information presented in K5, minimal documentation in the record reflected assessment findings that were demonstrated to be current, accurate or complete.</td><td>Noncompliance</td></tr>
<tr><td>K7</td><td>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.</td><td>Records reflected 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.

<table><tr><td></td><td>10/2010</td><td>5/2011</td><td>Change</td></tr><tr><td>Psychological Assessments included an intellectual assessment that had been administered within the past five years and an adaptive assessment that had been completed in the past year</td><td>Zero of 36 (0%)</td><td>Zero of 18 (0%)</td><td>0%</td></tr></table></td><td>Noncompliance</td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the</td><td>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 and data collection practices were under development. This was the second consecutive site visit during which RSSLC failed to provide the requisite documentation.

Due to the lack of treatment plans, it was not possible to review non-PBSP psychological</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	efficacy of treatment.	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 had failed to comply 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. Consent and approval formswere typically in the chart for PBSPs, restrictive procedures and the use of psychotropic medication. Documentation of the consent and approval process reflected basic time and procedural requirements were frequently met, but several lapses were noted during the site visit. • For Individual #112, the PBSP was dated 3/2010. The PST approved the intervention on 3/4/2010 and the Peer Review committee offered approval on 4/15/2010. The HRC review was dated 3/3/2010, prior to the PST or PRC approval. The HRC approval also stipulated that the next HRC review would be required by 2/2011. The record did not contain documentation of an HRC review since approval was granted on 3/3/2010. • For Individual #146, the most recent PSP was dated 12/9/2009 with the most recent PBSP dated 2/2010. The most recent HRC approval was dated 4/1/2010 and indicated the next required HRC review would be 1/2011. There was no documentation of HRC review in 2011. • For Individual #162, several HRC review forms were included in the chart. As none of the forms were dated, it was not possible to determine which approval was the most recent or if any of the approvals were current. One of the targets of this PBSP was pica. • For Individual #429, the PST approved the PBSP on 8/25/2010 and the Behavior Therapy Committee approved the plan on 9/7/2010. PRC review did not occur until 10/3/2010. HRC review and approval was 12/2/2010. One of the targets of this PBSP was self-injury. • For Individual #758, the PBSP was dated 1/12/2011. PRC reviewed and approved the intervention on 1/24/2011, but HRC review was not conducted until 3/3/2011. 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, it is suggested that the Facility is placing the individuals, their peers and Facility staff in prolonged risk by not acting prudently and promptly. Similar trends were noted during previous site visits, indicating that RSSLC had not acted prudently nor invested the necessary effort and coordination into reducing the unnecessary risk to individuals living at the Facility.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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.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 the 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. The majority of PBSPs reviewed at RSSLC included steps to address all aspects of the contingencies of the undesired target behaviors. Without rigorous and comprehensive assessment, however, these proposed steps relied primarily upon subjective opinion and educated guesses. Such interventions possess a lower probability for success than do interventions based on current, generally accepted standards and can precipitate the eventual use of more intrusive procedures. At the time of the site visit, and as had been documented at all site visits including the baseline visit, RSSLC did not utilize adequate behavioral assessment procedures. For example, functional assessments did not include all expected components, did not clearly identify behavior functions, and did not identify functional replacement behaviors.	

#	Provision	Assessment of Status	Compliance
		Furthermore, measurement of targeted behavior was limited by vague operational definitions, inadequate staff training, and data collection methods that produced data of questionable validity. Because these essential elements of the treatment development process were lacking, the behavioral interventions produced by this process were at best unlikely to produce substantial changes in undesired behavior. In situations where undesired behavior could result in risk of harm to the individual or their peers, there existed the potential for an inadequate behavioral intervention to allow a possibly harmful behavior to continue.	

PBSP Element	4/2010	5/2011	Change
Rationale for selection of the proposed intervention.	0%	6%	6%
History of prior intervention strategies and outcomes.	0%	0%	0%
Consideration of medical, psychiatric and healthcare issues.	0%	6%	6%
Operational definitions of target behaviors.	21%	28%	7%
Operational definitions of replacement behaviors.	0%	17%	17%
Description of potential function(s) of behavior.	0%	6%	6%
Use of positive reinforcement sufficient for strengthening desired behavior	0%	11%	11%
Strategies addressing setting event and motivating operation issues.	8%	11%	3%
Strategies addressing antecedent issues.	0%	11%	11%
Strategies that include the teaching of desired replacement behaviors.	0%	11%	11%
Strategies to weaken undesired behavior.	0%	6%	6%
Description of data collection procedures.	0%	6%	6%
Baseline or comparison data.	0%	11%	11%

#	Provision	Assessment of Status	Compliance

Treatment expectations and timeframes written in objective, observable, and measureable terms.	0%	6%	6%
Clear, simple, precise interventions for responding to the behavior when it occurs.	0%	100%	100%
Plan, or considerations, to reduce intensity of intervention, if applicable.	0%	0%	0%
Signature of individual responsible for developing the PBSP.	0%	83%	83%

As the data reflected, the status of PBSPs remained well below standards acceptable within the field of applied behavior analysis. This was particularly evident in relation to the formal teaching of replacement behaviors, the identification and use of powerful reinforcement strategies, the use of true pretreatment or baseline data, the establishment of objective and meaningful treatment expectations, and precise instructions for data collection. Examples of weaknesses are presented below.

- For Individual#86, the following problems were noted in the PBSP.
  - Documentation had suggested that anxiety served as a setting event for undesired behavior. The role of anxiety had not been ruled out during the assessment process. The PBSP, however, contained no behavioral procedures for reducing the experienced anxiety. If anxiety was a setting event, the failure to address anxiety in the PBSP placed substantial constraints on the efficacy of the PBSP.
- For Individual #91, the following problems were noted in the PBSP.
  - Assessments had indicated that escape was an important function of behavior and that attention from staff did not have substantial value for the individual. The PBSP, however, instructed staff to use pats on the back and verbal praise as reinforcement for desired behaviors.
  - The PBSP included steps to teach the individual to use appropriate behavior to avoid undesired activities or items. The methodology included presenting the individual with “a choice of one or two non-preferred activities/items, ask him if he wants to participate or engage with the activity/item. If he says no, the staff member should acknowledge his answer by either repeating what he said or by saying something like, ""you don't want this. Okay."" And then the staff person should move away with the item.” Although this procedure appeared

#	Provision	Assessment of Status	Compliance
		rational, it was actually less efficient than the forms of inappropriate escape and avoidance in the individual's behavior repertoire. As a result, the PBSP had the potential to strengthen rather than weaken the undesired behavior. • For Individual #630, the following problems were noted in the PBSP. o The process to teach the replacement behavior included these steps: 1) Staff will assist the individual to identify things that he wants or needs, 2) If he does ask for something appropriately, praise him for doing so, 3) If he does not, teach the individual how to ask for something in a more appropriate way such as "May I talk to you"?, or "May I play this game with you"?, and 4) After he does praise him for doing so. This methodology lacked the details and specificity necessary for consistent implementation. The intervention lacked guides for prompting, instructions for documentation, and the potential for high rates of reinforcement. o The instructions for addressing displays of self-injury included as the first step, "In the event of self-injury, quietly and respectfully ask him to stop." There was no indication in the behavior assessment that requesting that he stop is an effective approach to stopping the self-injury. As a result, this approach could increase the potential for injury to the individual. o The goals and objectives for the program included the following expectations: 1. The individual will exhibit 10 or less incidents of aggression to others by 6/1/11. 2. The individual will exhibit 18 or less incidents of aggression to self by 6/1/11. 3. The individual will exhibit 2 or less incidents of leaving without informing staff by 6/1/11. 4. The individual will exhibit replacement behaviors on 80% of possible occasions by 6/1/11. The time parameters included in the expectations were not based upon expectations for the behavior derived from careful assessment, but rather by the individual's next annual PSP. The arbitrary use of annual PSP dates for treatment expectations increases the probability that an ineffective PBSP will be continued for too long, thereby denying meaningful services and potentially increasing the risk to the individual. Based upon the information obtained during the current site visit, there was little evidence to indicate that RSSLC had achieved progress toward satisfying this Provision of the Settlement Agreement.	

#	Provision	Assessment of Status	Compliance
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 had not been any routine assessment of the actual quality of behavior data. At the time of the current site visit, however, the Facility had just implemented a process for reviewing data quality and establishing inter-observer agreement. Due to the recent initiation of this process, it was not possible to assess the benefits of the process. 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 18 of 18 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 18 of 18 records (100%), treatment objectives were stated in terms of total frequency while data were presented as daily mean frequency per week. • In 18 of 18 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 #618 included three data graphs with three different Y-axis maximum values (.04, .14, and .40). 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 three of 18 records (17%), the maximum value of the Y-axis changed from one month to the next.. This can lead to misinterpretation when comparing data month to month. • In 18 of 18 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. • In seven of 18 records (39%), the graph legend covered a substantial portion of the data points and data path on the graph. By blocking the data points from view, the ability to determine intervention response was substantially impaired. Despite the problems noted above, RSSLC did achieve some progress in areas related to	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>the graphic presentation of data.

<table>
<tr><td>Graph Element</td><td>4/2010</td><td>5/2011</td><td>Change</td></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Horizontal axis and label</td><td>8%</td><td>83%</td><td>75%</td></tr>
<tr><td>Vertical axis and label</td><td>8%</td><td>83%</td><td>75%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>0%</td><td>6%</td></tr>
<tr><td>Data points and path</td><td>100%</td><td>78%</td><td>-22%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>

Despite the areas of progress, the quality of data and data graphs at RSSLC fell far below accepted standards for applied behavior analysis. As the Settlement Agreement requires compliance within 18 months for this Provision, considerable effort will be required by the Facility in order to achieve compliance.</td><td></td></tr>
<tr><td>K11</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.</td><td>During the current site visit, 18 PBSPs were reviewed regarding readability. In order to assess readability objectively, Microsoft Word 2010 was used to establish the Flesch Reading Ease score and the Flesch-Kincaid Grade Level for the sections of each PBSP intended to be read by DCPs.

The Flesch Reading Ease test rates text on a 100-point scale. The higher the score, the easier it is to understand the document. For most documents, an acceptable score is between 60 and 70. The Flesch-Kincaid Grade Level test rates text on a U.S. school grade level. For example, a score of 8.0 means that an eighth grader can understand the document. For most documents, a score of approximately 7.0 to 8.0 is acceptable.

The average Flesch Reading Ease score for the PBSPs was 68.43, with a range of 59.4 to 81.4. The average Flesch-Kincaid Grade Level for the PBSPs was 7.53, with a range of 5.1 to 8.6.

This indicates the PBSPs were readable. However, Instructions to staff lacked specificity and substantially reduced the probability of consistent implementation.</td><td>Noncompliance</td></tr>
<tr><td>K12</td><td>Commencing within six months of the Effective Date hereof and with</td><td>At the time of the baseline visit in April, 2010, the Monitoring Team determinedthat a competency-based approach to staff training for PBSPs was not in place.During the</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	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.	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 October 2010 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. At the time of the current site visit, a system for assessing staff competence and providing competency-based training for DCP staff had just been implemented by the Behavior Services department. Insufficient time had elapsed since the implementation of the assessment and training process to allow for assessment.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the site visit, RSSLC employed four staff members who possessed board certification as a behavior analyst for 384 individuals at the Facility. This represented approximately one BCBA for every 96 individuals 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 32 individuals residing at the Facility. Recognizing that not all individuals require a PBSP, this would bring the Facility into compliance with this provision once all these staff complete certification. 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.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should develop a plan to ensure that behavior assessments and interventions conform to accepted behavior analytic practices
2. The Facility should review the current Peer Review practices and implement the necessary steps to ensure that the peer review process operates under formal guidelines, produces objective and measurable benefits, and includes both internal and external components.
3. 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 timeframes, allows for prompt implementation of behavior intervention, and ensures that the information needed for informed consent is provided.

4. 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.
5. The Facility should act to ensure that the need for intellectual and adaptive assessment is recognized and that intellectual and adaptive testing is conducted according to expectations.
6. The Facility should act to ensure that a comprehensive case formulation process is implemented that includes the formal integration of behavior assessment into the process for diagnosing and treating mental illness, as well as the consideration of mental illness in the functional assessment process. In addition, there should an integration of behavioral correlates and symptoms of mental illness in the assessment of personal status and treatment progress.
7. The Facility should review current practices regarding behavior assessment and intervention, and develop procedures that ensure that disparities in findings from functional assessments are addressed through additional assessments, including objective observation.
8. 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.
9. 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.
10. 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 competency-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, dated 4/18/2011 2. Texas Department of Aging and Disability Services, Office of Management Support and Oversight of State Schools, Policy Directive 09-001, Clinical Death Review, Revised 3/09 3. Texas Department of Aging and Disability Services, Office of Management Support and Oversight of State Schools, Policy Directive 09-002, Administrative Death Review, Revised 3/09 4. RSSLC Administration: Actions Following Death of Individuals Served, A.7, Revised: 1/5/11 5. Active clinical record of Individuals #321, #134, #530, #625, #284, #765, #477, #655, #375, #308, #161, #162, #361, #723, and #728 6. Untitled draft of a local policy for the Physician Quarterly Review, dated February 18, 2011 7. Physician Quarterly Review form (blank copy), dated February 18, 2011 8. Local Chronic Clinical Indicator policy, draft, undated 9. Completed Chronic Clinical Indicators for diabetes, hypertension, hyperlipidemia, and osteoporosis 10. Draft local policy for "Acute Clinical Indicators", undated 11. Blank copy of "Acute Clinical Indicator" form. 12. Pneumonia committee meeting minutes for November 2010, December 2010, January 2011, and February 2011 13. Memo regarding Aspiration Pneumonia Prevention Plan, dated December 3, 2011 14. Consultation report for Dental Clinic, form 8529, April 2005 15. Nurse Practitioner Practice Agreement 16. On-Call Medical Guideline, dated April 8, 2011 17. Ten Medical Provider Quality Assurance Audits, completed by off-site clinicians (physician and nurse practitioner) that reviewed Individuals #508, #213, #426, #800, #69, #551, #378, #729, #796, and #95 18. RSSLC Emergency Medical Response Committee Meeting Minutes, 10/21/10, 12/30/10, 2/28/11, and 4/14/11 19. RSSLC Debriefing Notes for Infirmary Cardiopulmonary Resuscitation (CPR) Drill, 10/28/10 20. RSSLC Automated External Defibrillator (AED) Location and Equipment Sheet and Map

	21. RSSLC Emergency CPR Drills – Monthly Schedule of Completed Drills, 12/2010 through 3/2011 22. RSSLC Monthly Mock CPR Reports, 9/2010 through 2/2011 23. RSSLC Competency Training and Development (CTD) Course Delinquent List for Basic Life Support (BLS) for Health Care Providers, Printed: 4/4/11 24. RSSLC Health Care Services, Conducting Mock Medical Emergency Drills Policy, 1.01, Revised: 2/24/11 25. American Heart Association (AHA) Basic Life Support for Healthcare Providers, Written Examination, Version B, Date : 2/2006 26. American Heart Association Instructor Update Course, Date 2010 27. RSSLC E-mail communication regarding Availability of Online AHA Instructor Update Course 28. Death Reviews for Individuals: #186, #607, #217, #418, #491, #750, and #454 **People Interviewed:** 1. Meeting with Tran Quan, M.D., Medical Director 2. Meeting with Individual #765's health care team, that included his QMRP, Lenin Mathews; nurse Bhavika Patel; physical therapist Estrellita Posadas; and physician, Dr. Fuentez, to discuss the case 3. Donald Pavliska, Competency Training and Development Director 4. Wilma Parker, RN, Quality Assurance Nurse 5. Robyn Partridge, RN, Quality Assurance Nurse **Meetings Attended/Observations:** 1. Individuals #321, #134, #530, #625, #284, #765, #477, #655 were observed at their living area 2. Observations of Individuals at the Facility's vocational workshop 3. Observations of Individuals at Trinity B, and TJ5 4. At Risk team meetings for Individuals #363 and #385
	Facility Self-Assessment: For Provision L1: The Facility has initiated many meaningful improvements at the Facility; however, they report that they remain non-compliant with Provision L.1, of the Settlement Agreement. Based on its review, the Monitoring Team concurs with the Facility's self-assessment. For Provision L2: The Facility reports non-compliance with Provision L.2, of the Settlement Agreement. The Monitoring Team notes the implementation of a system to conduct Medical Chart Audits; however, because this process does not effectively assess clinicians' clinical performance, the Monitoring Team agrees with the Facility's assessment. For Provision L3: The Facility informed the Monitoring Team that it does not have a comprehensive method to conduct a quality improvement process for medical services. The Facility has developed a very impressive "Chronic Clinical Indicators" and is working on developing "Acute Clinical Indicators", which will lead the Facility towards compliance. The Monitoring Team agrees with the Facility's assessment. For ProvisionL4: The Facility had determined itself not to be in compliance with Provision L.4, as it continues to work to develop standard of care practices. At the time of the review, the Facility had

	developed some meaningful clinical indicators and DADS Central Office continued to work on developing and implementing clinical pathways. The Monitoring Team concurs with the Facility's self-assessment.
	Summary of Monitor's Assessment: The Monitoring Team recognized the efforts, diligence, and dedication of the Medical Director, Dr. Quan, and the Medical Staff at the Facility. Although significant adverse outcomes were noted by the Monitoring Team, the Monitoring Team recognized that major system issues, such as the inability of theFacility to efficiently collect, maintain, and report clinical data; inadequacies of the team process; and the inability of nursing and direct care staff to appropriately and timely triage clinical issues, are rate limiting issues that prevent clinicians from providing high quality medical services at the Facility. The Monitoring Team would like to make it exceptionally clear that this report does not reflect adversely on the clinician's ability to practice medicine, but does delineate the need for the Facility to ensure that all staff, including clinicians, nurses, pharmacists, physical therapists, occupational therapists, psychologists and direct care staff, work together to better identify early signs and symptoms of clinical deterioration and prompt, efficacious evaluation and treatment, through resolution of any clinical condition, including acute medical conditions and exacerbation of chronic medical conditions. For Provision L.1: The Monitoring Team concurs with the Facility and determined that the Facility did not comply with Provision L.1, of the Settlement Agreement. The Monitoring Team notified the Facility that significant and prompt work is needed to enhance nursing staff's ability to triage acute and decompensating chronic medical conditions, and direct care staff's appropriate and timely reporting of changes in status,and that improved reporting of clinical status updates to clinicians is fundamental to compliance. The Monitoring Team also noted in its review of clinical records that documentation practices must be enhanced to better delineate clinical issues, diagnostics, treatments, clinical plan, and outcomes of clinical conditions. Importantly, the clinical records didnot enable efficient collection and reporting of clinical data and information. Clinical data and information was fragmented within the clinical record and did not lead to efficient retrieval to make necessary and timely decisions by clinicians at the Facility. The Medical Staff had put forth significant effort in their development or enhancements of medical related policies, procedures, and practice. The Facility had developed and partially implemented a "Chronic Clinical Indicators" process that is intended to provide Facility Clinicians with up to date knowledge of current clinical standards of care for common and serious conditions. As part of an Aspiration Pneumonia Prevention Plan, the Facility developed an "Aspiration Clinical Pathway." The pathway was developed by medical and other professional staff at the Facility and was in-serviced to nurse managers, clinicians and members of the pneumonia committee. The Medical Director initiated an "Integrated Morning Meeting." The meeting consists of all clinicians, psychiatrist, clinical pharmacist, habilitation coordinator, nurse case managers, QMRPs, behavior analyst,

	unit directors and direct care staff, and meets every Wednesday to discuss a predetermined case, which is based on changes in functional status of an individual, or if there was recent and challenging hospitalization of an individual. The Medical Director had established a process to improve communication and working relationships with local hospital systems. Since the last the review the Facility had made improvements in the Emergency Response System. A formalized Mock Medical Emergency Drill Schedule was implemented and the Facility tracked completed drills. An Emergency Response Committee was established and implemented to analyze and trend Mock Medical Emergency Drill data, take corrective action when necessary, and to improve the Mock Medical Emergency Drill procedures. Review of the Committee minutes since the initial meeting showed progressive improvement in the analysis and trending of the completed Mock Medical Emergency Drills as well as corrective action taken when employees failed to perform adequately at the drills. Monthly Mock CPR Drill Reports were generated from the Mock Medical Emergency Drill data and sent to the Settlement Agreement Coordinator who sent the reports to the State CTD Office. The Monitoring Team's review of completed Mock Medical Emergency Drill forms indicated that nurses did not consistently participate in drills and physicians never participated in the drills. The Facility needs to ensure that nurses and physicians participate in drills, unless there is justification for their failure to participate in the drills. According to the CTD Course Delinquent List, four employees were delinquent in BLS Basic Life Support for Health Care Workers and 26 employees were delinquent in Basic CPR training. The Facility should ensure that all required employees are current in BLS Basic Life Support for Health Care Workers and/or Basic: CPR training. The Facility continued to use the outdated AHA 2006 Basic Life Support for Healthcare Providers training program. The Facility should update the CPR training and use the AHA 2010 version for Basic Life Support for Healthcare Providers. For Provision L.2: The recently initiated Medical Chart Audit is an excellent mechanism to help identify various activities by the clinicians, such as documentation practice and following up on various conditions. The Monitoring Team determined that the Facility had not developed a mechanism to assess clinicians' ability to practice medicine and therefore concurs with the Facility's assessment of remaining non-compliant with Provision L.2, of the Settlement Agreement. Since the last review the Facility had seven deaths. In six of the seven deaths (86%) the Facility had completed Administrative and Clinical Death reviews. One recent death was pending completion of the review process. The Facility failed to consistently comply with their death review policies for the following reasons: The requirements for completing the various processes and timelines were not consistently met. The disciplines required to attend the Death Review Committees were not consistently present. Recommendations were not carried out timely. The Facility did not have a database or other process to track recommendations to resolution. The Facility had two policies that were inconsistent in the required processes and timelines. In order to meet compliance with this Section of the Settlement Agreement the issues listed above must be resolved.

	For Provision L.3:Because of the lack of a Medical QA process, the Monitoring Team agrees with the Facility, and has determined that the Facility remains noncompliant with Provision L.3 of the Settlement Agreement. However, based on the high quality of the Chronic Clinical Indicators and Acute Clinical Indicators, the Monitoring Team is encouraged and recognizes that the Facility is on a good heading in becoming compliant with the Provision. For Provision L.4: Based on its review of the status of the development of Clinical Pathways, Chronic and Acute Clinical Indicators, observations of individuals at their living area and review of clinical records (see Provision L.1), the Monitoring Team agreed with the Facility and determined that the Facility is out of compliance with Provision L.4 of the Settlement Agreement. Compliance will require full implementation of practice standards and Individuals benefiting from such enhancement.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Facility reported to the Monitoring Team that it remained out of compliance with Provision L.1, of the Settlement Agreement. To assess the Facility's efforts to gain compliance, the Monitoring Team reviewed active clinical records, reviewed new and updated policies and procedures, observed individuals at their living area and workshop, and conducted interviews with staff. The Monitoring Team recognized the significant effort put forth by the Medical Director, and Medical Staff, in their development or enhancements of medical related policies, procedures, and practice. During its review for Provision L.1, the Monitoring Team assessed the following enhancements, which were introduced within the past six months: 1. In April of 2011, the Facility began the development of a "physician quarterly review" process, which was a new process of the Facility. This process involves physicians at the Facility to comprehensively review their caseload and document relevant clinical issues of each individual on a Physician Quarterly Review form. The Monitoring Team reviewed this process and associated draft policy and forms and recognized its potential to assist physicians and other clinical staff better understand the clinical needs of each individual and improve clinical outcomes. 2. The Facility had developed and partially implemented a "Chronic Clinical Indicators" process that is intended to provide Facility Clinicians with up to date knowledge of current clinical standards of care for common and serious conditions. In this process, each clinician was assigned a topic (and additional topics will be assigned);the clinician is to research current practice standards and provide other clinicians at the Facility with an in-service on completed	Noncompliance

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		indicators. Completed indicators are printed and disseminated to all Clinician staff providers. The Medical Director maintains a file of all indicators and will provide copies to new clinical staff as they are brought on board. The Facility had a draft policy for this process. At the time of this review, Clinical Indicators for Hypertension, Osteoporosis, Hyperlipidemia, Chronic Congestive Heart Failure, Hypothyroidism, and Diabetes Mellitus had been developed. The Monitoring Team complimented the Medical Director, Medical Staff and others who participated on this most impressive work. 3. Under the leadership of the Medical Director, the Facility had begun the development and implementation of an "Acute Clinical Indicator" process. The process was intended to provide Clinical staff with greater insight in the management of acute medical conditions at the Facility. The Medical Director continues to develop the process and reported to the Monitoring Team that they will implement a pilot program by the time of the next review. The Monitoring Team noted the potential benefit of this process, but cautioned the Facility to ensure that clear expectations are provided on the part of not only clinical staff, but direct care and nursing staff as well. As will be discussed later in this report, the Monitoring Team had identified that nursing staff were not triaging clinical issues, as appropriate, and direct care staffdid not report for review by the nurse and physician (and other clinicians) changes in status that were important, and nursing staff did not identify and report to physicians health issues that needed to be addressed nor to establish which issues needed to be addressed immediately. 4. In December of 2010, the Medical Director had initiated a "Pneumonia Committee" to address the Facility's high number of pneumonia cases, including aspiration pneumonia. In these meeting, issues such as improvement in infection control, educating direct care staff about signs and symptoms of aspiration pneumonia, the need for more aggressive oral hygiene, monitoring for position, and deploying most experienced staff to homes that have high rates of aspiration risk were discussed. From such discussions, action steps were developed that included: developed a list of high risk individuals for aspiration pneumonia; in-serviced direct care staff on signs and symptom of aspiration pneumonia; developed a system to ensure proper bed elevation with a chain system attached to bed; nursing staff provided personnel for night time position checks; infection control nurses received support to enforce hand hygiene; and dental office developed a pilot suction tooth brush program. The Monitoring Team was very impressed with the efforts put forth for this new process, and if action steps are appropriately implemented and monitored for compliance, the process should reduce aspiration, aspiration pneumonia and serious outcomes	

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		secondary to all types of pneumonia. No policy had been developed for this process and the Monitoring Team raised concerns about staff compliance with recommendations and the Facility's ability to self monitor staff for compliance with recommendations. 5. As part of an Aspiration Pneumonia Prevention Plan, the Facility developed an "Aspiration Clinical Pathway." The pathway was developed by medical and other professional staff at the Facility and was in-serviced to nurse managers, clinicians and members of the pneumonia committee. Nurse managers further in-serviced nursing staff. The Monitoring Team noted the efforts of all who participated, and further recommended that competency based training continue for all clinical and direct care staff. Early recognition of signs of choking, aspiration and pneumonia is paramount in protecting individuals served by the Facility. Furthermore, the Monitoring Team highly recommends that staff be trained on the unique manifestations of pneumonia in some people who experience intellectual and other disabilities, such as lack of mounting an elevated white blood cell count or temperature, inability to develop pulmonary infiltrates early in the disease process, and dangers of subtle dehydration, which can promote the development of sepsis. 6. The Medical Director initiated an "Integrated Morning Meeting." The meeting consists of all clinicians, psychiatrist, clinical pharmacist, habilitation coordinator, nurse case managers, QMRPs, behavior analyst, unit directors and direct care staff, and meets every Wednesday to discuss a predetermined case, which is based on changes in functional status of an individual, or if there was recent and challenging hospitalization of an individual. The Monitoring Team noted that this meeting functions similarly to a morbidity committee meeting and compliments the Medical Director and participants of this process. The Monitoring Team recommended that a formal policy be developed that clearly delineates the function of the meeting and responsibilities of each member. It is essential that all assignments that are derived from the meeting are track for completeness and efficacy. The Monitoring Team attended the meeting and observed that clear objectives and assignments must be made for each outstanding issue that was addressed. Comprehensive minutes should be prepared that outline each issues, objective and assignment. 7. The Medical Director had updated all medical care policies for the Facility. The Monitoring Team did not review the updated policies. 8. Under the direction of the Medical Director, staff clinicians had begun updating all standard order forms and created new forms as necessary. An example of	

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		one newly developed standardized order, for dental consult to assess the safety of initiating individuals on bisphosphonates, was reviewed by the Monitoring Team at the time of the review (although new, it was apparently incorrectly still dated April 2005). 9. The Facility was piloting a process to provide "bed-side" Pro-time and International Normalised Ratio instead of sending the lab sample to a reference lab. This will minimize blood draws to the individual and enable more readily lab results, which are critically needed to adjust anticoagulation therapy. The Monitoring Team will follow-up on this process at the time of subsequent reviews. 10. Nurse Practitioner practice agreement was enhanced and implemented by the Facility. This process enables a clear understanding of the role of the Nurse and the supervising physician. The Medical Director maintained a log of all cases reviewed with the nurse Practitioner. The Monitoring Team noted that the Facility did not have an actual policy that reflects the practice of utilizing Nurse Practitioners. 11. The Emergency Medical Response Committee was enhanced by ensuring that a physician is involved in the committee, and efforts to enhance this committee further will be initiated. 12. The Medical Director had established a process to improve communication and work relationship with local hospital systems. At the time of this review, the Monitoring Team was invited to a regularly scheduled meeting, which included leadership from one hospital system that is relied on frequently. This process will be expanded to include other Facilities in the future. The Monitoring Team attended this meeting and recognized its benefits, such as better communicating adverse outcomes and system issues that hinder care among the providing institutions. The Monitoring Team recommended that a formal policy be develop that clearly outlines the meetings' functions. Importantly, comprehensive minutes should be maintained that documents issues of concern, objectives, expected outcome objectives, assignments and actual outcomes form improvement initiatives. 13. A non-facility medical chart audit had been developed through the State Office. The Facility had one audit visit by clinicians from Brenham and Austin. The Monitoring Team reviewed ten audits conducted by alternate site clinicians (Physician and Nurse Practitioner). This is described in more detail for	

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		Provision L2. 14. The Medical Director had developed on-call medical guidelines. This process better enables nursing staff to provide on-call physicians with critical information necessary to triage a clinical matter while on-call. A copy of Guidelines for this process was provided to the Monitoring Team. The Monitoring Team recommended that a formal policy be developed to ensure that the process is maintained at the Facility. Importantly, the Monitoring Team discussed the need to enhance the guidelines and to ensure that staff explicitly follows the guidelines. The Monitoring Team reviewed the following clinical records to assess clinical management related to the diagnosis and treatment of osteoporosis in male individuals: 1. Individual #162 was prescribed oral alendronate for the diagnosis of osteoporosis, which was made by DEXA scan on 11/22/04. There was no indication of a follow-up DEXA noted in the active clinical record. Neither the annual medical summary, physician progress notes,nor the PSP commented on the individual's diagnosis and treatment for osteoporosis. There were no labs to support a comprehensive assessment for the etiology of osteoporosis. It is essential that all individuals who are initially treated for osteoporosis are assessed for etiologies that manifest with low bone density, especially parathyroid disease, among others. 2. Individual #161 was prescribed oral alendronate for the diagnosis of osteoporosis, which was made by DEXA on 10/06/08. The annual medical evaluation noted "Despite treatment with Fosamax, Calcium and Vitamin D3 supplements, he still has osteoporosis"; however, the Monitoring Team was unable to find a follow-up DEXA scan or written report in the active clinical record to support that claim. The Monitoring Team was unable to identify laboratory data to indicate an assertive evaluation to assess for the etiology of osteoporosis in a male. 3. Individual #375 was prescribed alendronate for the diagnosis of osteoporosis, which was made based on a DEXA scan on 4/20/10. The individual also had a diagnosis of bilateral undescended testes. Concern for possible cancer was noted on the ultrasound report, dated 10/4/10. The urology consultation recommended a follow-up scrotal ultrasound in 12 months and return to clinic. The Facility Clinician accepted the Consultant's	

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		recommendationand indicated that she would recheck the scrotal ultrasound in six months. The Monitoring Team raised concern that this new finding might require more assertive follow-up, and questioned why direct contact with the Consulting Urologist was not initiated by the Facility. The PSP quarterly review dated 3/31/11, commented that the individual has a diagnosis of osteoporosis but did not question the etiology of osteoporosis in this male Individual. The Annual PSP did not reflect on important monitoring issues for osteoporosis. Importantly, the PSP did not comment of the new finding of a mass lesion on the individual's testicle. Review of integrated progress notes failed to provide evidence that the individual's testicles were regularly assessed for possible enlarging mass, pain or discomfort. Review of comprehensive nursing assessment dated 11/23/10 did not comment on the individual having a new mass lesion on his testicle, nor was nursing follow-up recommended. Review of laboratory data demonstrated a mildly elevated alkaline phosphatase on 4/12/11. The physician comment on the elevated alkaline phosphatase in the progress notes and stated "alk P remains high secondary to osteoporosis." Given a possible malignancy of the testicle, the Monitoring Team raised concerns that the elevated alkaline phosphatase may be secondary to bone metastasis. Following review of laboratory diagnostics, the Monitoring team could not find an assessment to help determine the etiology of osteoporosis in a male. 4. Individual #308 was prescribed alendronate for the diagnosis of osteoporosis, which was determined by DEXA scan on 3/3/11. Review of laboratory data did not support that an assessment had been performed to determine the etiology of the low bone density, prior to initiating treatment. The Monitoring Team reviewed Clinical Records to assess the Facility's ability to manage diabetes mellitus: 1. Individual #530 was observed at the Facility's vocational workshop. When asked, the Individual had no problems to report. The Individual denied problems with ambulation, foot pain and discomfort. The Individual reported that she believed her care was "good." In addition to having diabetes, the Individual was prescribed psychotropic medications for Bipolar Disorder that included clonazepam, risperidone and quetiapine. The Individual takes metformin and prn regular insulin for diabetes. The Monitoring Team identified that the diagnosis, as listed on the Annual Medical Summary, did not indicate the type of diabetes the person has--diabetes mellitus type I or type II	

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		(IDDM/NIDDM), or diabetes insipidus; the active problem list, however, indicated Diabetes Type II, while the optometry consult indicated Diabetes Type I. Review of the Individual's active clinical record demonstrated the following: The preventive care flow sheet indicated the need for daily aspirin; A1C every six months or at the physician's discretion; annual lipids or at clinician's discretion; annual urine microalbumin and creatinine; annual dilated eye examination; and annual foot exam. Optometry exam dated 3/11/211 demonstrated normal fundus. There was no evidence to indicate a podiatry examination. The Annual Medical Summary dated April 6, 2010, noted that the clinician documented "intact" for sensory exam; however, the clinician did not specifically address assessment for neuropathy (autonomic and peripheral neuropathy) or indicate that the exam was unable to be completed. Also, although the clinician documented that skin had normal turgor, the clinician did not specifically address a foot examination, and the Individual has an active diagnosis of onychomycosis of toenails. Lipid levels were within normal levels. The A1C was elevated at 6.5, indicating a mean blood glucose level of 124, which is an expected range. The Monitoring Team did not find evidence of a urine microalbumin and creatinine being completed, as required. The Occupational Therapy/Physical Therapy evaluation dated 2/11/11 indicated that the Individual experienced frequent falls secondary to autonomic dysfunction; however, this issue was not reported on the Quarterly PSP Review, and there was no evidence to suggest assertive evaluation or management for this serious condition. The Individual was noted to have macrocytic anemia with an MCV of 103.9, RBC of 3.29 and hemoglobin of 11.5 and hematocrit of 34.2 (normal 36). The Individual was prescribed iron supplementation for anemia. For colon cancer screening there was one occult fecal blood test documented in the clinical record; however, the clinician ordered a total of three to be done, which is what is indicated. The Monitoring Team did not find evidence to suggest a comprehensive work-up for anemia, despite being prescribed chronic iron supplementation. The DISCUS assessment dated 3/7/1 was not completed by the physician (no conclusion or comments documented). Review of the Quarterly PSP Review, dated 2/28/11, was devoid of any	

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		comment regarding the issue of risks of metabolic syndrome while taking antipsychotic medications and having a diagnosis of diabetes mellitus; the risks associated with atypical antipsychotics in an individual with known diabetes must be delineated and well understood by the team. The Quarterly PSP Review did not comment on the issue of the anemia for which she was prescribed ferrous sulfate for. Importantly, the Quarterly PSP Review did not comment on the issue of frequent falls related to autonomic dysfunction and reported episodes of vomiting as mentioned in the Annual Occupational Therapy and Physical Therapy Evaluation and Annual Medical Summary. There was a discrepancy between the Active Problem List and the diagnosis noted on the Annual Medical Summary: The Medical Summary did not list the type of diabetes the Individual has; the Problem list did not document the diagnosis of constipation. The Individual is prescribed ferrous sulfate for a diagnosis of iron deficiency anemia; however, the diagnosis was not listed on the Problem List or Medical Summary. 2. Individual #361 had a psychiatric diagnosis of schizoaffective disorder and was prescribed an atypical antipsychotic, quetiapine. The Individual was also diagnosed with diabetes mellitus type II and was prescribed metformin. Additionally, the Individual had a diagnosis and was receiving treatment for hyperlipidemia and hypertension. The Individual also received treatment for chronic constipation. The Admission Medical Summary, dated 11/05/10 documented a foot exam that noted "moist, macerated skin between 3rd, 4th, and 5th toes of both feet", and that sensation was "grossly intact." There were no optometry or ophthalmology consultations in the clinical record, nor was a slit lamp exam completed to assess for diabetic retinopathy. Blood pressure was noted to be 130/90. There were no recommendations to follow-up on the individual's macerated toes; however, the Individual was referred to podiatry on 11/5/10 for diabetic foot assessment. There was no recommendation to follow-up on the noted hypertension. In addition, the Preventive Health Care Flow Sheet for this individual, and others did not adequately reflect current recommendations for the management of diabetes. Review of laboratory values indicated an A1C of 7.0 on 1/26/11, which is above ADA target recommendations. Three month follow-up A1C was not found in the clinical record nor ordered. Urine for microalbumin was not completed. Neither the PSP dated neither 12/03/10, nor subsequent addendums, discussed	

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		or commented on the issue of being on an atypical antipsychotic medication and the diagnosis of diabetes, hypertension and hyperlipidemia. Risks and benefits of continuing the atypical antipsychotic in light of the Individual's known diagnosis of diabetes, hypertension and hyperlipidemia,, hence metabolic syndrome, must be carefully considered through the Team process. 3. Individual #723 had a diagnosis of diabetes type II that required both insulin and oral treatment, and was on ziprasidone for a behavior diagnosis. The individual's diabetes was regularly and timely managed by an endocrinologist; however, the Individual continued to have poorly controlled diabetes and evidence of end-organ damage that included diabetic retinopathy. The consulting endocrinologist had ensured appropriate and timely diagnostics were completed. The individual had followed up with podiatry and ophthalmology. The Facility's Annual Medical Summary Physical Examination that was completed on 12/29/1 was comprehensive and documented an appropriate foot examination. The sensory component of the examination did not assess neuropathy. Review of laboratory studies demonstrated a elevated fasting glucose level and elevated A1C of 8.3, on 1/27/11. The PSP, dated 1/26/11, did not reflect the seriousness of the Individual's poorly controlled diabetes. There was no evidence that indicated awareness of the PST and LAR of cumulative risk of being on atypical antipsychotics and diabetes. There was no evidence that the PST and LRA understood the significance of the individual's blindness in one eye and diabetic retinopathy in the other. 4. Individual #728 had a diagnosis of diabetes that required oral medication, metformin. The Individual also had a diagnosis of schizophrenia for which olanzapine, an atypical antipsychotic, was prescribed. The physical exam, noted on the annual medical summary, dated 3/10/11, documented a comprehensive diabetic assessment. Recommendations for diabetes were present and appropriate. Review of labs indicated a slightly elevated A1C, of 7.1, dated 3/21/11. Lipids were noted to be within normal limits; however, there was no indication that a urine for microalbumin was completed.	

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		Review of the annual PSP, addendum to the PSPs and the annual comprehensive nursing assessment, dated 3/25/11, demonstrated lack of assertive evaluation by the Team to address this individual's diabetes and known diagnosis of metabolic syndrome, which in this case was associated with glucose intolerance, dyslipidemia and obesity, with recent weight gain and continued use of the atypical antipsychotic, olanzapine. The Monitoring Team reviewed three additional clinical cases that demonstrated the administration of poor primary care services: 1. Individual #134: At the time of observing Individual #134 at his home, the Monitoring Team waited for 27 minutes while the Individual was using the restroom unassisted. The Monitoring Team was unaware of how long the Individual was in the rest room prior to its arrival at the living area. Direct care staff then assisted the individual from the restroom and at that time the Monitoring Team observed that the Individual appeared to be having significant respiratory difficulty, with a respiration rate of 38 and employing all accessory muscles to assist with respiration. The Monitoring Team requested that his nurse assess the individual and asked if the Individual's signs were normal or common. Direct care staff and nursing staff reported to the Monitoring Team that the Individual appeared worse then he usually does and that he woke up feeling ill and has been demonstrating respiratory difficulties for at least two days. The nurse also commented that the individual had difficulties with breathing and moderate congestion. Review of integrated progress notes on 5/2/11 and 5/3/11 indicated that at 2:35 pm on 5/2/10, nurses administered albuterol nebulizer treatment for shortness of breath. At 4:00 pm, the nurse indicated that she was "still awaiting return call from MD." There was no documentation stating that the physician returned the call to the nurse. On 5/3/11, at 6:15 am, the nurse reported that the Individual was wheezing and had a nonproductive cough, and that she would notify the on-call physician. The nursed documented at 7:00 am, that the physician retuned the page and she notified the physician that the Individual had wheezing, shortness of breath and non-productive cough and with oxygen at 2 liters. No new orders were received and the nurse referred the Individual to 'sick call." At the time of the Monitoring Team's assessment, oxygen was not in place. The Monitoring Team immediately notified the Facility's Medical Director of its concerns of a possible medical emergency. The Facility's physician assessed the individual at 10:30;the physician triaged the Individual to the local acute	

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		hospital. The Monitoring Team clearly recognized the many co-morbid and severe medical conditions the Individual was diagnosed with; however, the Monitoring Team raised concerns of the individual not being assessed by the Facility physician sooner, and that nursing staff did not demonstrate a sense of urgency, based on the significant change in function and observed distress, especially in an Individual with known serious medical conditions that included restrictive lung disease, chronic heart failure, and history of recurrent pneumonia. From this observation and by review of the above clinical records, the Monitoring Team was of the opinion that both nursing staff and direct care staff did not have a fundamental understanding on how to appropriately assess individuals with developmental disabilities for acute medical conditions or decompensation of chronic medical conditions. In this case, nursing staff did not complete appropriate nursing assessments for acute and decompensating clinical conditions. Most important, nursing staff did not provide the physician with appropriate, meaningful and timely clinical information, hence, the physician was unable to make sound, rationale clinical decisions, which in turn results in poor care and adverse outcomes to Individuals served by the Facility. This issue was discussed in detail by the Monitoring Team with the Medical Director, who fully concurred with the Monitoring Team's assessment. Additional information regarding related nursing issues are reporting in the Provision for nursing services. 2. Individual #284: Individual #284 was observed at his home, in a wheel chair, and bundled up with multiple blankets. The Monitoring Team asked direct care and nursing staff who were attending to his needs, why he had so many blankets. The nurse responded b they were taking him off campus and that he has a diagnosis of hypothermia. Review of his latest Annual Medical Summary, dated 1/15/10 (four months over due for current years annual), listed the Individual as "prone to hypothermia, use thick clothes and insulation." The Summary also reported significant cardiac issues and questioned the possibility of pulmonary hypertension. A cardiology consult report, dated 4/0/09, reported "abnormal echo due to LVH from chronic lung disease and possible pulmonary hypertension. Return to clinic prn."The most recent annual PSP, dated 2/9/10 (three months overdue for current years annual), did not comment on his significant cardiac condition. Review of most recent quarterly nursing assessment, dated 8/4/10 (six months	

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		overdue for nursing assessment), did not comment on the individual's significant cardiopulmonary condition. The review did comment on hypothermia and stated "Hypothermia: risk for altered body temperature below normal range related to inactivity, aging, illness/trauma, damage to hypothalamus or decreased metabolic process." No specific nursing instructions were indicated for this condition. Following review of the clinical record, the Monitoring Team could not find assertive evaluation or management for either hypothermia or his cardiopulmonary condition. The etiologies of these conditions were not stated and there was no evidence that indicated that a search for the etiology of these conditions was identified in the Clinical Record. 3. Individual #765: The Monitoring Team observed Individual #765 at his home. The Individual was sitting upright in a wheel chair, being provided with enteric tube nutrition. The Monitoring Team observed the Individual as having generalized spasticity of the extremities and severe contractures of the right and left wrist, to the extent that hygiene was a challenge. The Individual was seen by neurology on 3/24/11, and was administered Botox injections for spasticity. The Facility was to evaluate every four weeks and if benefit was noted, the Individual was to receive continued therapy in six months. The Annual Medical Summary, dated 3/16/10 (which was two months overdue for this year's annual), documented "spastic quadriplegic cerebral palsy", and "profound mental retardation with multiple contractures" as current medical diagnoses. These diagnoses did not comply with ICD 9, diagnosis codes. The physical exam commented on "retractile testicles, into inguinal area; no palpable nodules; no hernia; surgical scar right inguinal area". There was no plan specific to these conditions listed. A renal Ultrasound was obtained on 2/14/11 for recurrent urinary tract infection (UTI). The ultrasound demonstrated hypoechoic masses seen in the left kidney and CT follow-up was recommended. Follow-up CT was obtained on 2/24/11 that demonstrated renal lithiasis in both kidneys. It also demonstrated prostate hypertrophy with calcification measuring 5.2cm by 3.2 cm. Evidence of constipation with fecal impaction in the rectum was also noted on the CT. The Individual was seen on 11/29/11 by urology who noted marked	

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		enlargement of the right testicle and left undescended testicle. Prior ultrasound{US} of 11/10/09 demonstrated bilateral undescended testes. The Individual was seen again by urology on 2/25/11; this consult report documented prominent prostate size with no nodules. On 3/17/11 the individual underwent shockwave lithotripsy for renal lithiasis, and was to return for follow-up in one month, along with a KUB x-ray. On 4/7/11 a KUB x-ray was obtained to follow-up on kidney stone. The x-ray was "extremely limited due to motion" and they could not evaluate the renal lithiasis; however, diffuse bowel ileus was seen. A flexible sigmoidoscopy was obtained on 11/4/09 that demonstrated hemorrhoids. At the time of this review, 5/4/11, no follow-up x-rays were identified in the clinical record. The Clinical record (Occupational Therapy Annual Planning Meeting report of 4/8/10), indicated the individual had a history of recurrent UTIs, history of kidney stones and that a CT of the abdomen on 6/18/09 demonstrated bilateral renal stones, stone in the distal left ureter, multiple stones in the urinary bladder and mild hydronephrosis. On 9/11/09 urology recommended day surgery for left retrograde pyelogram and left ureter stone manipulation, which was done on 12/14/09. The Quarterly PSP, dated 2/9/11, did not comment on hypothermia, or issues related to renal lithiasis. The report indicated no impaction and that miralax was working well. Both conditions were recent diagnoses of the Individual. The report did not comment on the urology consultation on 11/29/11, which noted an enlarged right testicle. There were no addendums to the PSP to discuss the important issues of follow-up on the lithotripsy that was done on 3/17/11, or to discuss follow-up for colonic ileus, fecal impaction, enlarged testicle, or enlarged prostate. At the time of the Monitoring Team's review, the most recent Annual Nursing Assessment located in the clinical records was dated 3/15/10, and the most recent Quarterly Nursing Assessment was dated 11/23/10. Nursing assessment did not adequately reflect the Individual's health care needs. <u>Emergency Response System/Mock Medical Emergency Drills</u> Since the last review the Facility had made numerous improvements to the Emergency Response System and in Mock Medical Emergency Drills. Improvements included the following: • A formalized Mock Medical Emergency Drill Schedule was implemented and the Facility tracked completed drills. This was validated through review of the Emergency CPR Drills – Monthly Schedule of Completed Drills, 12/2010 through	

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		3/2011. Approximately 90 drills were completed monthly. • Completed Mock Medical Emergency Drills were turned in to CTD within 24 hours of completion. Mock Medical Emergency Drill Reports were analyzed and trended monthly by CTD. The completed reports were sent to the Settlement Agreement Coordinator who was to submit the reports to the State CTD Office. This was validated through review of the Mock CPR Reports, 9/2010 through 2/2011. There was no validation available to demonstrate that the reports were sent to the State CTD Office. • The Mock Medical Emergency Drills Policy, 1.01, was revised: 2/24/11. The revised policy provided more explicit guidance than the previous policy. It also included the formalized establishment of an Emergency Response Committee which meets monthly to monitor the effectiveness of training and to review Mock Medical Emergency drills for effectiveness, identifying trends, and determining root causes. The team consisted of the CTD Director, Medical Director, Nursing Director, Security Manager and Risk Manager or designee. This was validated through review of the revised policy and Emergency Response Committee Minutes 10/21/10, 12/30/10, 2/28/11, and 4/14/11. The monthly Emergency Response Committee Minutes for 11/2010, 1/2011, and 3/2011 were not available for review, therefore; it could not be determined if those monthly meetings occurred as specified in the policy. It was positive to find that the recommendation made at the last compliance review to establish and implement an Emergency Response Committee that included the Medical Director and Chief Nurse Executive had been accomplished. The first formation of the Emergency Response Committee meeting occurred in 10/2010. Review of the Committee minutes since the initial meeting showed progressive improvement in the analysis and trending of the completed Mock Medical Emergency Drills as well as corrective action taken when employees failed to perform adequately at the drills. Examples of improvements made through the Committee's review of drill performance included the following: o The 12/30/10 Committee minutes included a review of drills conducted in October and November, 2010. In October the minutes indicated that staff in Trinity and Infirmary were slow to respond to the drill. Three employees were recommended for a refresher course in CPR. At the time of the Committee meeting, two of the employees no longer worked at the Facility. The one remaining employee who was recommended for refresher CPR training was reported to have received the training on 11/4/10. It was positive to find that the Committee followed-up to ensure that the employee received refresher CPR training. o The 12/30/10 and 2/28/11 Committee minutes included a review of drills conducted in 12/2010 and 1/2011. There were no deficiencies identified for the 12/2010 drills. In 1/2011, the Forever Young area failed the drill with four	

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		deficiencies. Drill items not met were: First person at the scene calls help, escort Emergency Medical Service (EMS) to the scene, staff in the area responded immediately to the scene, and request AED and mask. Staff performing the drill had to be prompted by the instructors. The supervisor for two employees recommended for refresher CPR training was notified by e-mail on 2/1/11 of the need for training due to poor performance at the 1/30/11 drill. At the time of the Committee meeting it was reported that one employee received refresher CPR training on 2/16/11 and the other employee did not receive refresher CPR training. The instructors encountered "restrictions" (quarantine) in Leon when a drill was attempted. The staff told the instructor no one was allowed in or out of the building. Questions arose about the definition of restriction versus quarantine. The instructor asked if signs should be posted if a unit was under restriction. The nurse on the committee was to check with the Infection Control Nurse on the policy. o It was positive to find that the Medical Director and Chief Nurse Executive attended and participated in the 4/14/11 Committee meeting. The minutes included the following information: The result of the 3/2011 drills were reviewed. Lists of issues/concerns were discussed regarding the drills conducted in at the Day Program, Forever Young, San Antonio A and B. Employees for whom refresher CPR training was recommended were identified and the reasons for their poor performance were identified. The minutes failed to include the status of the refresher CPR training for the employee who was identified in the 2/1/11 as not having completed the training. The minutes included a discussion regarding team's need to meet after actual CPR was performed. The team agreed to meet by the third day after CPR was used to debrief. It was suggested that all staff involved in responding to the CPR event should attend the debrief meeting. This procedure was to be added to the CPR policy. This was a positive finding and was not done previously. The Facility did not have a public address system. The Medical Director brought up the use of pagers. She stated the pagers were recently updated. She asked for a list as to who was on the list to be paged. No one had a list; the Medical Director was to obtain the list. She recommended who should be paged, such as, Physicians, Campus Nurses, Unit Nurses, 4444 pager, and Respiratory Therapy. Who was being paged was not consistent. The Medical Director will update the Medical policy. The Medical Director requested a list of medical personnel delinquent in CPR. The Committee minutes, 4/14/11, failed to include a follow-up discussion regarding status of posting signs on units under restriction/quarantine, as was	

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		discussed in the 2/1/11 Committee Minutes. The Facility's Emergency Response Committee needs to ensure that issues identified in previous Committee Meetings that required follow-up are addressed at the next meeting, e.g., evidence that refresher CPR training was completed for employees' who were recommended for such training. • A list of AED locations was provided for review. AEDs were located in all areas of the Facility except in the Kitchen, Maintenance, and Laundry. The list for these areas stated, "This is an older model we can not get replacement parts of Compact Disc (CD) for they are in the nursing administration supply room." The Facility should ensure that the Kitchen, Maintenance, and Laundry have working AEDs. This is particularly important since these buildings are located far away from the medical complex. The Facility should ensure that location of each AED is clearly identified with a sign to ensure they are readily identifiable and accessible. The Monitoring Team identified issues through document review and interviews that need improvement. Issues included: • The CTD Course Delinquency Lists identified four employees (three nurses and one physician) delinquent in BLS for Health Care Providers. These were apparently new employees since there was not a date for last taken. • The CTD Course Delinquency Lists identified 26 employees who were delinquent in CPR Basic. As was found at the last review some employees were delinquent for more than one year, e.g., one employee's last date taken was in 2001; three employees last date taken was in 2007; nine employees last date taken was in 2008; 10 employees last date taken was in 2010, and three employees were listed as not applicable because there was no date last taken, apparently new employees. The Facility should ensure that all required employees are current with Basic Life Support and/or Basic CPR training. • Review of completed Mock Medical Emergency Drill forms did not indicate whether the drill was passed or failed. The form used did not contain a space at the top of the page to indicate pass or fail. If any of the items on the drill form are marked "no" or left blank the drill should be considered failed, unless the staff were prompted on the spot. In that case, the form should have been corrected to reflect item(s) the staff performed correctly. • The Monitoring Team's review of the completed Mock Medical Emergency Drill forms did not agree with the Facility's Mock CPR Reports. Numerous drill forms did not indicate that nurses and/or physicians participated in the drills. Therefore, the emergency equipment was not checked on the forms. For the drills to be considered passed the nurses must be present and check the emergency equipment, unless there was rationale documented explaining why the nurses and physicians did not	

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		participate. The Facility should to ensure that nurses are familiar with the operation of all emergency equipment through demonstration during the drills. This is essential to ensure that when an emergency arises, the equipment is available and the nurses are competent in operating the equipment. When the nurses and/or physicians do not participate in the Mock Medical Emergency Drills, the Mock Medical Emergency Drill instructors should evaluate the reason why the nurses and physicians did not participate in the drills. Unless there was a justifiable reason why nurses and/or physicians did not participate in the drill, the drill should be considered a failure. • The Facility continued to use the American Heart Association's 2006 version for CPR training. This version is outdated and there have been numerous changes made in the last five years. According to the CTD Director the delay was due to awaiting approval for purchase of the American Heart Association's 2010 training materials. The Facility should ensure that American Heart Association's 2010 training materials are purchased and implemented as soon as possible. • Copies of the AED and Emergency Equipment Checklists for the last six months were not provided in the document request for review. Blank forms for the AED and Emergency Equipment Checklist were submitted in the document request along with instructions for completion, e.g., the Nurse Manager assigns a nurse (RN or LVN) to check the AED, Oxygen, and Suction Machine every shift. A sample size is one Checklist per month per unit. Therefore, it was not possible to determine if the AED and Emergency equipment was checked daily on each shift as required. The Oxygen Checklist only contained the date and shift to be checked. The Oxygen Checklist did not require recording the pounds per square inch (psi) of pressure remaining in the oxygen tank on the checklist. This is important in order for the nurses to be able to calculate the amount of oxygen remaining in the tank and to ensure that an adequate amount of oxygen is available at all times. The Nursing Department needs to revise the Oxygen Checklist to include checking the pounds per square inch (psi) of pressure left in the oxygen tank and train the nurses how to calculate the psi. • The Monitoring Team's review of the Quality Assurance Plan (draft) did not include monitoring Mock Medical Emergency Drills. The Quality Assurance Director should consider including monitoring Mock Medical Emergency Drills activities, which may facilitate the identification of problematic issues which otherwise might go unrecognized. The Monitoring Team also noted in its review of clinical records that documentation practices must be enhanced to better delineate clinical issues, diagnostics, treatments, clinical plan and outcomes of clinical conditions. Importantly, the clinical records do not enable efficient collection, and reporting of clinical data and information. Clinical data	

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		and information is fragmented within the clinical record, and does not lead to efficient retrieval to make necessary and timely decisions by Clinicians at the Facility. Specific to the monitoring of medication side effects, the Monitoring Team reviewed all individuals at the Facility who were on the combination of valproic acid and lamotrigine (Individuals #328, #124, and #751). The combined use of these two medications hasthe potential of manifesting serious and life threatening side effects that may occur at anytime during administration of the medication, hence, requires prudent monitoring for as long as the combination is administered. Following its review of progress notes in the active clinical record and the past 12 months of MOSES assessments, the Monitoring team noted that no additional screening for side effects was conducted by the Facility, outside of the regularly scheduled six month MOSES assessment. All individuals on such combination of medication must be routinely monitored. Importantly, the PST must represent this risk and document it in the PSP. Review of the PSP did not demonstrate appropriate documentation to reflect such drug utilization. This issue highlights deficiencies at the Facility in routinely monitoring Individuals for side effects to medications. The Monitoring Team will enhance its effort in assessing how the Facility monitors medication side effects, upon subsequent reviews. Following its review, the Monitoring Team concurs with the Facility and determined that the Facility did not comply with Provision L.1, of the Settlement Agreement.	
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.	Working towards compliance for Provision L.2, of the Settlement Agreement, the Facility, along with DADS Central Office, developed a process to conduct medical chart audits. A Physician and a Nurse Practitioner from different SSLCs completed a non-Facility physician review on February 9th, 10th and 11th of 2011. A standardized form was used as the tool in reviewing each record. This included 33 items with a yes/no or not applicable (N/A) result, and room for comments. The tool included essential items that were asterisked, and must be met to have an acceptable rating, in addition to achieving an average score of 80%. Essential concerns included a determination of: whether the active problem list was in the correct location, that it was dated, and that it was updated with each new problem and updated as problems resolved; and whether the annual physical exam and summary were current and complete, and whether it included significant medical events of the past and present, as well as records reflecting drug/food allergies, sensitivities, or reactions. The Monitoring Team reviewed a total of ten Medical Chart Audits from this review. These medical peer reviews were completed on Individuals # #508, #213, #426, #800, #69, #551, #378, #729, #796, #95. Following review of the Medical Chart Audits, the Monitoring Team recognized that the	Noncompliance

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		Medical Chart Audits is an excellent mechanism to help identify various activities by the clinician, such as documentation practice, and following up on various conditions. Many of the questions focused on administrative issues, i.e. were progress notes signed, dated, and timed. It would be helpful to review specific problems to determine if treatment was appropriate. This would allow feedback to be provided regarding treatment of specific conditions, such as treatment of pneumonia, UTIs, or GERD, etc. More specifically, Questions #17 and #26 were all encompassing and extremely broad. It would be helpful to have a #26.a, and have the reviewer go through the record to track a specific diagnosis (e.g., GERD, aspiration pneumonia, constipation. It was difficult to determine the depth of the review when the answer to #17 and #26 was simply "yes."The Monitoring Team, however, has determined that this process is valuable but should be supplemented by a means to assess eachclinician's understanding of clinical conditions, core competencies, and practice. Although this audit system is a useful beginning, the Monitoring Team has determined that the Facility had not yet developed a mechanism adequate to facilitate the quality of medical care and performance improvement and does not yet comply with this provision. <u>Administrative and Clinical Death Review Process</u> The Monitoring Team, with participation of the Quality Assurance Nurses, reviewed the Administrative and Clinical Death Reviews and the accompanying recommendations for the seven deaths that occurred over the past six months. The purpose of the review was to monitor the Facility for compliance with their death review policies as well as the quality, appropriateness, and completeness of the recommendations generated from the Administrative and Clinical Death Review Committees. The Monitoring Team was provided with two different death review policies, e.g., Texas Department of Aging and Disability Services, Office of Management Support and Oversight of State Schools, Policy Directive 09-002, Administrative Death Review, Revised 3/09 and RSSLC Administration: Actions Following Death of Individuals Served, A.7, Revised: 1/5/11. Neither the Monitoring Team nor the Quality Assurance Nurses were able to determine whether both policies were operational or if the policy revised 1/5/11 superseded the revised 3/09 policy. The processes and timelines contained in these policies were inconsistent. This made it impossible for the Monitoring Team to determine compliance with this required activity of quality review for performance improvement. The Facility needs to review the two death review polices, e.g., Texas Department of Aging and Disability Services, Office of Management Support and Oversight of State Schools, Policy Directive 09-002, Administrative Death Review, Revised 3/09 and RSSLC Administration: Actions Following Death of Individuals Served, A.7, Revised: 1/5/11 and reconcile the inconsistencies between the polices or eliminate one of the policies.	

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		Monitoring Team's review of the cause of death data revealed the following information. This data will serve as a benchmark for reviewing future causes of death:	

Cause of Deaths for Seven Individuals Occurring from 11/2010 through 5/2011
1. Pending Death Certificate: Per Hospital Diagnosis: Acute Aspiration Pneumonia
2. Primary Cause of death: Malignant Neoplasm of Colon Underlying Causes: Respiratory Failure Renal Failure
3. Primary Cause of Death: Encephalopathy Underlying Causes: Malnutrition Cerebral Palsy with End Stage Degenerative Change
4. Primary Cause of Death: Septicemia Underlying Causes: End Stage Cerebral Degenerative Disease Pneumonia Seizure Disorder
5. Primary Cause of Death: Aspiration Pneumonia Underlying Causes: Severe Pharyngeal Dysmotility Myocardial Infarction
6. Primary Cause of Death: End Stage Cerebral Degeneration Underlying Causes: Aspiration Pneumonia Cardiopulmonary arrest due to sepsis
7. Pending Death Certificate: Probable Cause of Death Sepsis

It was of concern to note that three of the seven (43%) deaths either had a primary or underlying cause of death listed as Aspiration Pneumonia/Pneumonia and three of the seven (43%) deaths either had a primary or underlying cause listed as Septicemia/Sepsis. According to the Quality Assurance Nurses the Facility did not perform retrospective analyses and trends of deaths occurring at the Facility to identify rates of deaths and contributing factors related to the incidents of deaths. The Facility

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		should consider a retrospective study of deaths occurring at the Facility for at least the past two years to identify death rates and contributing factors related to the incidents of deaths in order to learn from complications and errors, to modify clinical practices and judgments based on past experience, to prevent repetition of errors leading to complications, and to identify areas of improvement for clinicians and other disciplines as well as identify system issues which affect individuals' care. The Monitoring Team reviewed seven of the Clinical Death Review Committee's Reports for compliance with the Clinical Death Review Policy. One review was not due until 6/5/11. The reviews included the following findings: • The physicians' Death Review Summaries were completed within five calendar days in zero of the seven (0%) deaths. • The Unusual Incident Investigation was completed within five working days in seven of the seven (100%) deaths. • The Clinical Death Review Committee met within 14 calendar days (or 45 calendar days in cases in which autopsy is performed, or for death occurring at medical facilities off campus) in five of the six (83%) deaths. One review was not due until 6/5/11. • The Medical Director was present at four of the six (67%) Clinical Death Reviews. . • The Nursing Director was present at two of the six (33%) Clinical Death Reviews. • The Attending Physician was present at four of the six (67%) Clinical Death Reviews. • The Nursing Supervisor was present at zero of the six (0%) Clinical Death Reviews. • An outside physician was present at zero of the six (0%) Clinical Death Reviews. There was no documentation regarding efforts to obtain outside physicians for Clinical Death Reviews. • The Clinical Death Review Committee Reports were completed within 21 calendar days after the death in four of the six (67%) deaths and sent to the Administrative Death Review Committee. One review was not due until 6/5/11. The Monitoring Team reviewed seven of the Administrative Death Review Committee's Reports for compliance with the Death Review Policy and found the following: • Clinical Death Review Summaries were submitted to the Administrative Death Review Committee within 21 calendar days (or 52 calendar days in cases in which autopsy is performed, or for deaths occurring at medical facilities off campus) for four of the six (67%) deaths for which the review was due. One review was not due until 6/5/11.	

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		• The Facility Director was present at four of the six (67%) of the Administrative Death Reviews. • The Medical Director was present at four of the six (67%) of the Administrative Death Reviews. • The Nursing Director was present at four of the six (67%) of the Administrative Death Reviews. • The Public Representative was present at four of the six (67%) of the Administrative Death Reviews. • There was no documentation available for review validating that within 14 calendar days of the receipt of the information from the Clinical Death Review Committees and Administrative Death Review Committees that the Facility submitted the information to the State Office Medical Services Coordinator. • There was no documentation available for review validating that within 28 calendar days following the submission of the Clinical Death Review Committees recommendations and Administrative Death Review Committee recommendations that the Facility Director or designee submitted a summary of the resulting actions taken in response to the recommendations of the Administrative and Clinical Death Review Committees to the State Office Medical Services Director. • There were zero autopsies performed on the seven individuals who died. The Monitoring Team reviewed the clinical data contained in "red folders" for all deaths. From the review of the clinical data and recommendations derived from the data, the Monitoring Team agreed that the recommendations appeared appropriate. The recommendations and follow-up actions were filed in each folder. The Facility did not have a database for tracking recommendation generated from the death reviews. There were numerous recommendations that did not contain verification that the follow-up actions of the recommendations were carried out to resolution. It was the responsibility of the Quality Assurance Program Auditor to track the completion of the recommendations. There was evidence that the Quality Assurance Program Auditor had sent out numerous e-mail reminders to the disciplines responsible for carrying out the recommendations but some recommendations remained incomplete. The Death Review Policies did not specify a timeframe for completing recommendations. This made it impossible to determine compliance with completing the recommendations. It is important that recommendations are carried out promptly in order to take corrective action to resolve and/or prevent the problems identified from being repeated. Examples where the recommendations were not completed promptly included: • Individual #186 died on 11/21/10. The cause of death was listed as Acute Aspiration Pneumonia. Two of the four (50%) recommendations were not completed. The recommendations were sent to the Medical Director and	

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		Nursing Department on 12/13/10. The recommendations outstanding included: o The Medical Director was responsible for developing policies and procedures for training direct care professionals on the basic clinical signs and symptoms of Aspiration Pneumonia and Sepsis.. The Medical Director's plan was to have this developed by May or June 2011. The delay in implementing this recommendation was of concern to the Monitoring Team. At the time of the Monitoring Team's compliance review the policies and procedures for training the direct care professionals on basic clinical signs and symptoms of Aspiration Pneumonia and Sepsis were not in place. Waiting five months to develop such training was unacceptable, particularly due to the fact that 43% of the deaths were attributable to Aspiration Pneumonia and Sepsis. o The Nursing Department was responsible for the recommendation to combine Nursing Policies E-02, E-04, and E-05 related to the assessment of vital signs to reflect current practice, monthly requirements, and to provide competency based training on the revisions. At the time of the review there was no validation that this was completed or any feedback regarding the progress made toward accomplishing the recommendation. Again, five months delay in completing this recommendation is unacceptable. • Individual #607 died on 11/29/10. The cause of death was listed as Malignant Neoplasm of Colon. One of the three (33%) recommendations was not completed at the time of the review. The Nursing Department was responsible for re-training the Nurse Case Manager responsible for Individual #217's care on developing Health Maintenance Plans. Again, the delay of approximately five months is unacceptable. The inability of this Nurse Case Manager to adequately develop a Health Maintenance Plan put the other individuals on his/her caseload at risk for inadequate care and has the potential to lead to complications. • Individual #217 died on 1/8/11. The cause of death was listed as Encephalopathy. However, the medical records reported that Individual #217 had an abdominal mass of undetermined etiology but was suspected to be ovarian cancer. One of the seven (14%) recommendations was not completed. The recommendation was sent on 2/9/11 to the Qualified Mental Retardation Professional Director responsible for completing the recommendation for the Person Support Team to take greater involvement with regard to terminal care and activities of daily living. At the time of the review there was no validation that this recommendation was completed. This represented a delay of at least two months. Again this length of delay in completing the recommendation is unacceptable.	

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		• Individual #418 died on 2/14/11. The cause of death was listed as Septicemia. Two of the two (0%) recommendations were not completed. The recommendations were sent to the Nursing Department on 3/17/11. One recommendation to re-train the nursing staff on documentation. The other documentation was to re-train Nurse Case Managers on the Comprehensive Nursing Assessment. At the time of the review there was no evidence that the recommendations were completed or feedback regarding status of the progress made toward completing the recommendations. This represented at least a six week delay in completing the recommendations. Again, this is unacceptable and has the potential to place individuals at risk of complications due to inadequate nursing assessments and documentation. • Individual #750 died 3/3/11. The cause of death was listed as Aspiration Pneumonia. Four of the four (0%) recommendations were not completed. The recommendations were sent on 4/25/11 to the respective disciplines responsible. At the time of the review it may have been too soon to expect the recommendations completed. • Individual #491 died on 3/15/11. The cause of death was listed as End Stage Cerebral Degeneration with secondary causes listed as Aspiration Pneumonia and Sepsis. Four of the four (0%) recommendations were not completed. The recommendations were sent on 4/25/11 to the respective disciplines responsible. At the time of the review it may have been too soon to expect the recommendations completed. • Individual #454 died on 4/20/11. The preliminary cause of death was probable Sepsis. The death review process was not completed at the time of the review. The Monitoring Team will follow-up on the incomplete recommendations at the next review. The Facility needs to develop and implement a database or other process to track recommendations from each Administrative and Clinical Death Review. The Tracking Log should include, at minimum, the following items: • Date of Death • Individual's Name • Home • Unusual Incident Number, as applicable • Recommendation(s) • Person Responsible • Due Date • Date of Completion The Facility needs to ensure that recommendations derived from the Administrative and/or Clinical Death Reviews are promptly completed by the assigned disciplines to	

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		resolve or prevent the problems identified from being repeated in order to minimize or eliminate health risks to individuals. It was positive to find since the last compliance visit the State had executed contracts with Quantros Patient Safety Center and Health Watch to perform external mortality reviews. According to the Quality Assurance Nurses the Facility had been copying and sending information on deaths to these organizations to complete mortality reviews. The Facility failed to consistently comply with their death review policies for the following reasons: The requirements for completing the various processes and timelines were not consistently met. The disciplines required to attend the Death Review Committees were not consistently present. Recommendations were not carried out timely. The Facility did not have a database to track recommendations to resolution. The Facility had two policies that were inconsistent in the required processes and timelines. In order to meet compliance with this Section of the Settlement Agreement the issues listed above must be resolved.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	At the time of this review, the Facility had not developed a quality assurance program; however, the Facility had developed "Chronic Clinical Indicators" that will be further developed and implemented into a database, which will enable trends analysis and monitoring for outcome studies. The Monitoring Team determined that the Chronic Clinical Indicators are a meaningful start to develop a high quality medical QA process. Because of the lack of a Medical QA process, the Monitoring Team agrees with the Facility, and has determined that the Facility remains non-compliant with Provision L.3, of the Settlement Agreement. However, based on the high quality of the Chronic Clinical Indicators and Acute Clinical Indicators, the Monitoring Team is encouraged and recognizes that the Facility is on a good heading in becoming compliant with the Provision.	Noncompliance
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	The Facility had determined that it remained non-compliant with Provision L.4, of the Settlement Agreement. The Facility reported to the Monitoring Team that it continues to work with DADS Central Office to develop Clinical Pathways for common and serious medical conditions. The Facility has also developed several very impressive Chronic Clinical Indicators that will serve to enhance the overall clinical practice at the Facility. Because the Clinical Pathways, and the Chronic and Acute Clinical Indicators, have yet to be completed, and based on observations of individuals at their living area and review of clinical records (see Provision L.1), the Monitoring Team agreed with the Facility and determined that the Facility is out of compliance with this provision, of the Settlement Agreement.	Noncompliance

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	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.		

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Ensure that all draft policies are completed and finalized prior to the next review.
2. In the chronic clinical indicator for Osteoporosis, ensure that specific recommendations are provided for males with low bone-density. Ensure that medical, nursing, and direct care staff recognize the possibility of spontaneous femoral fractures that is caused by bisphosphonates.
3. Develop policy for Pneumonia Committee
4. Ensure that outcomes of recommendations by all committees, including the Pneumonia Committee, are assessed. Also, ensure that staff is compliant with following recommendations. Failure to appropriately implement recommendations will lead to system failures.
5. Staff should be trained on the unique manifestations of pneumonia in some people who experience intellectual and other disabilities, such as lack of mounting an elevated white blood cell count or temperature, inability to develop pulmonary infiltrates early in the disease process, and dangers of subtle dehydration, which can promote the development of sepsis.
6. Regularly scheduled "competency based training" (and re-training) should be offered for all medical, nursing and direct care staff, specific to the identification of early signs of infections, especially pneumonia, and urinary tract infections.
7. All assignments that are derived from the Integrated Morning Meetings must be tracked for completeness and efficacy.
8. A formal policy must be developed that clearly delineates the function of the Integrated Morning Meeting and responsibilities of each member.
9. Comprehensive minutes that outline each issue, objective and assignment should be maintained for the Integrated Morning Meeting.
10. Ensure the date on the updated dental consult form reflects the date the form was updated.
11. Develop policy that clearly delineates the practice of utilizing Nurse Practitioners at the Facility
12. For the regularly scheduled meetings with participating hospital systems,comprehensive minutes should be maintained that document issues of concern, objectives, expected outcome objectives, assignments and actual outcomes from improvement initiatives..
13. A formal policy should be developed that clearly outlines the function, objectives and responsibilities of the regularly scheduled meetings with participating hospital systems.
14. The "On-Call Medical Guideline" must be enhanced.

15. A specific policy for the on-call process must be developed.

16. The Monitoring Team considers the Medical Provider Quality Assurance Audit as a mechanism to assess clinician's ability to accurately document and follow-up on diagnostics, however, the Team does not consider the audit as a mechanism to assess clinical competency. A mechanism to assess clinical competency must be developed and implemented.

17. Clinicians must better follow-up on clinical conditions. Following an acute condition or exacerbation of a chronic condition, the clinician must regularly follow-up on the individual until full resolution of that condition. Clinicians must follow-up on all chronic conditions based on community standards of care.

18. Nurses must better assess Individuals and be more aware of the clinical status of Individuals who have acute conditions and exacerbation of chronic conditions.

19. Nurses must enhance their ability to report accurate, timely and meaningful clinical issues to clinicians at the Facility.

20. Direct Care Staff must be better enabled to identify changes in functional and behavioral status and report subtle signs to nursing staff for assessment and possible referral to clinicians for further evaluation.

21. Specific to osteoporosis, it is imperative that Individuals are provided a comprehensive assessment for the underlying cause of low bone density, prior to initiating individuals on treatment for osteoporosis.

22. The PST and PSP process must be significantly enhanced to better address medical issues.

23. The Facility must improve its ability to collect, maintain and report clinical data, and information, as part of the clinical record.

24. The Facility must immediately enhance its ability to appropriately monitor Individuals for medication side effects.

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, 4/18/11 2. RSSLC Behavior Intervention, Use of Restraint, J.1, Revised: 3/1/11 3. RSSLC Behavior Intervention, Completing the Restraint Checklist/Monitoring Restraint Use, J.02, Revised: 3/1/11 4. Texas Department of Aging and Disability Services, State Supported Living Centers, Nursing Protocol: Pre-treatment and Post-sedation Monitoring, Date: 2/2011 5. RSSLC Policy: Nursing Services, I.00b, Effective: 4/1/11 6. Texas Department of Aging and Disability Services, State Supported Living Centers, Procedure: Medication Administration Guidelines, Date: 2/2011 7. RSSLC Nursing Procedure Manual, Hiring of Nursing Personnel, A.00, Dated: 2/24/11 8. RSSLC Nursing Procedure Manual, Administration of Oral Medications, Revised: 2/24/11 9. Texas Department of Aging and Disability Services, State Supported Living Centers, At Risk Individuals Policy/Aspiration Pneumonia Initiative: Frequently Asked Questions, Date 12/20/10 10. RSSLC On-Call Medical Guidelines, Date: 4/8/11 11. RSSLC Acute and Chronic Clinical Indicators Policy, Draft 12. RSSLC Administration, Quality Assurance Plan, Effective Date: 4/28/11 (copy marked draft) 13. RSSLC Administration, Quality Assurance Improvement (QA/QI) Council, Revised: 4/28/11 (copy marked draft) 14. RSSLC Infection Control Committee Meeting Minutes, 1/10/11 15. RSSLC Safety Committee Meeting Minutes, 1/31/11, 2/23/11, and 3/29/11 16. RSSLC Infection Control Rounds – Documentation for Environmental Surveillance and Hand Washing, 10/2010 through 3/2011 17. RSSLC Infection Control Manual; review of all policies and procedures 18. RSSLC Infection Control Training Materials 19. RSSLC Infection Control – Employee Illness Tracking Log 1/24/11 through 2/20/11 20. RSSLC Sample of Individual Vaccination Excel Database 21. RSSLC Infection Control – Monitoring Tool for Handwashing/Glove Use and Infection Control Monitoring Tool 22. RSSLC Pneumonia Committee/PNM Team Meeting Minutes, 11/22/10, 12/1/10, 12/8/10, 12/20/10, 12/22/10, 1/5/11, 1/26/11, 2/16/11, 23. RSSLC Skin Integrity Committee Meetings, 11/10/10, 11/17/10, 11/24/10, 12/8/10, 12/29/10, 1/12/11, 1/26/11, 2/2/11, 2/16/11, 2/23/11, 3/9/11, 4/6/11, 5/4/11 24. RSSLC Decubitus Report FY 2020 25. RSSLC Pharmacy Policy and Procedure Manual, Medication Errors/Variances, 01.05.20, Date: None 26. RSSLC Medication Error Reports, the last 10 committed and submitted in the document request 27. RSSLC Completed Monthly Medication Administration Observation, Medication Room Survey, and Medication Administration Record Audits, 10/2010 through 3/2011

	28. RSSLC Medication Error/Variance Committee Meeting Minutes, 1/20/11, 2/17/11, 3/17/11, and 4/12/11 29. RSSLC Pharmacy and Therapeutic Committee Meeting Minutes, 10/27/10, 1/25/11, and 2/12/11 30. RSSLC Nursing Medication Error Reports to Medication Variance Committee, 1/20/11, 2/17/11, 3/17/11, and 4/12/11 31. RSSLC Medication Administration Observation Form for Individual #375 completed by the Quality Assurance Nurse on 5/4/11 32. RSSLC E-mail Communication by Quality Assurance Nurse on 5/4/11 and E-mail Communication by the Infirmary Director on 5/4/11 33. RSSLC Index of Monthly Training, Training Materials and Completed In-Services Sign-in Sheets, 2010 and 2011 34. RSSLC Infirmary Admissions, 4/2010 through 3/2011 35. RSSLC Nursing Organizational Chart 36. RSSLC Record Request for Section 1 and 12 (Budgeted, filled and unfilled positions), 3/31/11 37. RSSLC Nursing Positions – Budgeted 38. RSSLC List of Nursing Staff for the Campus (Administrative), Infirmary, Living Units, and First Aid/Treatment Room 39. RSSLC Providing Health Care Services, Documenting Nursing Staffing, I.23, Date: 4/1/11 40. RSSLC Nursing Shift Reports for the Infirmary and Living Units, 10/10/10 through 4/2011 41. RSSLC Minimum Staffing for Nursing, 4/10/11 42. Record reviews of Individuals: #479, #481, #6, #797, #573, #442, #223, #264, #375, #348, #134, #740, #415, #632, #385, #149, #363, #498, #235, #267, #551, #286, #564, and #402 **People Interviewed:** 1. Jane Purcell, Assistant Director of Programs 2. Charlene McCurry, RN, Chief Nurse Executive 3. Constance Bowie, RN, Nursing Operations Nurse 4. Genniffer Moore, RN, Acting Nursing Operations Nurse 5. Wilma Parker, RN, Quality Assurance Nurse 6. Emma Purvey, RN, Infirmary Director 7. Robyn Partridge, RN, Quality Assurance Nurse 8. Adriano Soria, Jr., RN, Hospital Liaison Nurse 9. Kimberly Randel, RN, Infection Control Officer 10. Kelly Sandler, RN, Assistant Infection Control Officer 11. UgoNweke, RN, Nurse Educator 12. WickiffFawibe, RN, Skin Integrity Coordinator 13. Kay Rudasill, RN, Nurse Educator/Nurse Recruiter 14. Several RN Nurse Managers and RN Nurse Case Managers 15. Direct Care Professionals **Meetings Attended/Observations:** 1. Morning Nurse Managers' Meeting, 5/2/11 2. Personal Support Team Meeting for Individual #442, 5/3/11 3. Quality Assurance and Quality Improvement Council Meeting, 5/3/11

	4. Pneumonia/PNM Committee Meeting, 5/3/11 5. Medical Morning Meeting, 5/4/11 6. Medication Administration Observations in the Infirmary, 5/4/11 and 5/5/11 7. Medical and Nursing Meeting with Triumph Long Term Acute Care Facility, 5/3/11 8. At Risk Team Meetings for Individuals #363 and #385 9. Meeting with Quality Assurance Department Staff 5/4/11 10. Nurse Managers and Nurse Case Manager Meeting, 5/5/11 11. Medication Variance Committee Meeting, 5/5/11
	Facility Self-Assessment: For Provision M.1, the Facility stated they are not in compliance with this provision. RSSLC stated that since the last compliance review (10/2010), the nursing staff had been trained and policies implemented on nursing assessments, identification of health care problems, notification physicians of health care problems, monitoring, intervention, and appropriated recording of individual's health care status. Training remains ongoing as well as monitoring the progress of the nursing staff in identification of health care problems, notification of the physicians, and intervention as needed. Training since 10/2010 included: • 11/1/10 – In-serviced on Policy 010 Nursing Services which was implemented on 1/31/11; Notification of the Primary Care Provider (PCP) in a Timely Manner of any Changes in Condition; and Policy E-19 Weight of the Individuals. • 12/7/10 – In-serviced Nurse Case Managers on Individual Immunization Policy, F-03 Breast Exams Policy, and D-03a Menses Policy. • 12/09/10 – Quality Assurance Nurses gave a detailed in-service on documentation of the nursing assessments, including the summary of the Health Maintenance Plans to all Nurse Case Managers. • 12/9/10 – In-serviced on Health Maintenance Plans and Acute Care Plans (how to identify health care problems), Annual/Quarterly Nursing Assessments and Tardive Dyskinesia to all Nurse Case Managers. • 1/6/11 – In-serviced on Health Maintenance Plans and Acute Care Plans: Do not combine several risk factors, required for all medium and high health risks as well as chronic health conditions. Comprehensive Nursing Assessments including analyzing and summarizing data identified in the nursing diagnoses. • 3/24/11 – Reviewed State Policies on Seizure Records and Nursing Services to nursing staff. Implementation of revised state policies will start 6/2011. For Provision M.2, the Facility stated they are not in compliance with this provision. RSSLC stated the following activities were performed to meet compliance with this Provision: • 11/2/10 – Reports from weight database were reviewed monthly the Nurse Case Managers to address any dietary concerns. • 12/1/10 – Each Nurse Case Manager monthly reviews a copy of one nursing summary, one nursing assessment and documentation from the Integrated Progress Notes Any discrepancies or documentation not completed correctly resulted in retraining nurses. For Provision M.3, the Facility stated they are not in compliance with this provision. RSSLC stated the

	following activities were performed to meet compliance with this Provision: • 12/2010 – At Risk training initiated with Webinars from State Office regarding the new risk process. • 1/2011 – Training performed on individual homes regarding the At Risk process and Aspiration Pneumonia. • 1/2011 – Nurse Case Managers trained direct care staff on Aspiration Trigger Data Sheet. The training was competency-based. • 2/1/11 – Aspiration trigger Data Sheets were implemented by the nursing and direct care staff. Nursing staff monitor the data sheets daily. For Provision M.4, the Facility stated they are not in compliance with this provision. RSSLC stated the same activities were performed to meet compliance with this Provision as were reported in Provision 0.1. For Provision M.5, the Facility stated they are not in compliance with this provision. RSSLC stated the same activities were performed to meet compliance with this Provision as were reported in Provision 0.3, with the exception of the following activity: • 3/1/11 – Implemented the Aspiration Pneumonia/Enteral Nutritional Evaluation. For Provision M.6, the Facility stated they are not in compliance with this provision. RSSLC stated the following activities were performed to meet compliance with this Provision: • 11/1/10 – Continued Medication Observation Audits minimally eight per month per unit. The audit sheets are turned into the Nursing Operations Officer for review and education follow-up with training if necessary to minimize medication errors. • 12/1/10 – The first meeting of a unified Medication Variance Committee, which meets monthly, to oversee the trends in the medication variance in procuring, storing, dispensing, prescribing, and administering drugs. It was evident through review of training records and staff interviews that the training listed in the Facility's Self-Assessment was conducted. Providing the competency-based training on the Monitoring Team's Nursing Recommendations to the nursing staff was a good first step in responding to the recommendations but ensuring compliance with the recommendations cannot be achieved by a one-time training of the nursing staff. Verification that the recommendations were carried out can only be accomplished when they translate into actual practice that can be identified by the Monitoring Team. Further, it is important that the Facility recognize that compliance with the Settlement Agreement and Health Care Guidelines must not be solely limited to recommendations made by the Monitoring Teams at the time of the compliance reviews. Therefore, in order to achieve compliance, the Facility's Management Team and all relevant disciplines must have a thorough understanding of the requirements set forth in all sections of the Settlement Agreement and Health Care Guidelines. The Nursing Department's Presentation Book was not made available for the Monitoring Team to review. At the last compliance review the Nursing Department's Presentation Book was available for review and

	was most helpful to review because it detailed the activities performed toward meeting compliance.
	Summary of Monitor's Assessment: **Provision M.1:** The Facility's Plan of Improvement stated they were not in compliance with this provision. The Monitoring Team concurs with their findings. The Nursing Department continued to maintain nursing staffing without the use of agency nurses. It was positive to find since the last compliance review that the Nursing Department had developed and implemented a new policy for documenting nursing staffing coverage on 4/1/11. It was of concern with the exception of Trinity and the Infirmary, the 10-6 shifts for the other Living Units were not staffed with a full time nurse and continued to be covered by the Campus RNs based out of the Infirmary. Since the last compliance visit the Nursing Care Monitoring Tools had been reduced from 21 to 12. Interpretative Guideline had been developed to ensure that all monitors evaluated data in like manner and to address the quality of the clinical data. The Nursing Department in collaboration with the Quality Assurance Department trained the nurses on the use of the monitoring tools and began monitoring with the tools in 1/11. There was documented evidence contained in the completed Nursing Care Monitoring Tools that demonstrated that the Quality Assurance Nurses were beginning to analyze the available data and take immediate corrective action with individual nurses when deficiencies were identified on the monitoring tools; there had not yet been corrective actions on systemic issues. In addition to the Quality Assurance Nurses auditing the 12 Nursing Care Monitoring Tools, they also monitored other items that included: Emergency Equipment, Medication Rooms, positioning of individual according to their Physical and Nutritional Plans, Medication Administration Records, Narcotic Logs, and Medication Administration Observations. The Nursing Department developed and implemented a variety of other monitoring activities. This was best demonstrated with the comprehensive Documentation Audit process. It was positive to find that the Nursing Department had self initiated a process for improving documentation. It was impressive that this initiative had resulted in a 41% decrease in documentation errors for the documentation items audited. There was evidence that improvements were found in the technical quality of the documentation. The SOAP method of charting was used almost consistently. The Nursing Department needs to ensure that the quality of the nursing care is also monitored. The Acute Care Protocols were beginning to be followed through to resolution more consistently. On-Call Medical Guidelines were developed on 4/8/11 and the nursing staff were trained on the guidelines. This was implemented to improve prompt notification of physicians when individuals had a change in health status. There remains the need for the nursing staff to ensure that physicians are promptly notified when a change is observed in individuals' health and/or mental health status. It was positive to find that at the time of the compliance review the Facility did not have any active pressure sores. The Wound Care Nurse continued to maintain a Decubitus Tracking Report by the month. The tracking report included whether pressure sores were acquired at the facility or were hospital acquired. The Skin Integrity Committee Meeting Minutes for the last six months demonstrated that this Committee performed in the most integrated manner of any of the committees the Monitoring Team

	reviewed. The tracking report failed to analyze and trend pressure sore data. The Wound Care Nurse needs to develop and implement a trend analysis to identify systemic skin integrity problems so that corrective action plans can be established and implemented to prevent or minimize skin integrity issues. The Infection Control Nurses continued to track and report infectious disease data into the database developed at the last compliance review. However, the database had not yet been fully populated with all of the data that the database is capable of handling. This was partly due to the lack of time and human resources. The Infection Control Program was not provided with support staff to enter the data, as was suggested at the last compliance review. One of the Infection Control Nurses stated she would be resigning within the next week. When the second Infection Control Nurse resigns, it will be essential to fill that position; if it is not filled, there is likely to be further delay in the entry ofcritical infection control data. For the data to assist clinicians in decision making it must be current. The data is also necessary to perform data analyses for systemic trends that may require corrective action plans. The infectious disease data continued to be reported in numbers as opposed to rates. The infectious disease data needs to use a standardized methodology for calculating the rates of infections. Rates should be calculated for each living area and the Infirmary as well as for the whole facility. Rates should also include nosocomial and associated health care infection rates. Provision M.2: The Facility's Plan of Improvement stated they were not in compliance with this provision of the Settlement Agreement and the Monitoring Team concurs with their findings. Since the last compliance visit the Nursing Department had provided additional training on completing Quarterly and Annual Comprehensive Nursing Assessments. It was apparent the nursing staff were making concerted efforts to appropriately complete comprehensive nursing assessments. There was improvement in all sections of the assessment except with the overall nursing summaries. The Nursing Department needs to enhance competency-based training on how to analyze and summarize clinical data into a meaningful summary that reflects the progress or lack of progress toward achieving individuals' established goals and objectives for each identified health problem. Provision M.3: The Facility's Plan of Improvement stated they were not in compliance with this provision of the Settlement Agreement and the Monitoring Team concurs with their findings. Although the Nursing Department had provided additional training on developing Health Maintenance Plans and Acute Care Plans since the last compliance visit, little progress had been made toward individualizing plans to meet individuals' unique heath care needs. The Nursing Department needs to continue to monitor and enhance competency-based training on the development and implementation of Health Maintenance Plans and Acute Care Plans to meet compliance with this provision of the Settlement Agreement and health Care Guidelines. Provision M.4: The Facility's Plan of Improvement stated they were not in compliance with this provision of the Settlement Agreement and the Monitoring Team concurs with their findings. Since the last compliance visits numerous policies and procedures had been added and the nursing staff trained. The Nurse Educators need to review and revise training materials to ensure they are current and develop

	formalized lesson plans with competency-based testing for all training provided. In addition, the Nurse Educators need to develop and implement a database to track all training. Provision M.5: The new At Risk process demonstrated improvement over the previous Health Status Team review process. It allowed for more time for team members to review and discuss risk factors for each individual reviewed. It also allowed the opportunity for all team members who knew the individuals best to participate. However, the facilitators read each of the individuals' established risk scores and did not assertively elicit information from the team members. Much like the previous risk process the discussion of assessments followed the criteria on the tool with very little deviation. The facilitators need to elicit more discussion and all relevant clinical data should be explored in order to adequately and accurately determine individuals' level of risk for the relevant risk factors. The Facility's Plan of Improvement indicated they were not in compliance with this provision of the Settlement Agreement, which was consistent with the Monitoring Team's findings. Provision M.6: The Facility's Plan of Improvement stated they were not in compliance with this provision and the Monitoring Teams concurs with their findings. The most significant improvement was found with the development and implementation of the Medication Error/Variance Policy and formation of a Medication Error/Variance Committee. Although improvements were made with increased monitoring of medication administration practices and documentation since the last compliance review, the nurses in the Infirmary need to improve medication administrations practices. The Nursing Department needs to aggregate Medication Administration Observation data into a system to track, analyze, and trend the data to identify systemic issues and take corrective action on identified deficiencies. The Medication Error/Variance systems need to continue refinement in identifying all factors contributing to medication errors/variances.

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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.	Provision M.1 of the Settlement Agreement includes a variety of different nursing sub-section requirements that address various areas of compliance. These sections include staffing, quality assurance and peer review efforts, documentation and accessibility of clinical records, acute illness and injury findings, and infection control information. Information addressing Mock Medical Emergency Drills and Emergency Response Systems is included in Section L.1. Information addressing Death Reviews is included in Section L.2. <u>Staffing</u> It was positive to find since the last compliance review that the Nursing Department had developed and implemented a new policy for documenting nursing staffing coverage on 4/1/11. The Nursing Department reported that a new system for generating nursing staffing reports, and analysis of nursing staffing began in mid-April 2011. The recent moves of individuals across campus had created the need for a restructuring of the old	Noncompliance

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		staffing system. At present, and until the moves are completed, the Nursing Department was pulling the surplus nurses from units that may be overstaffed for that shift and sending them where they were needed. More information and data will be available in approximately one month, when there has been time to gather sufficient data. At the time of the compliance review 384 individuals resided at the Facility. According to the review of the information provided in the document request (Nursing Positions – Budgeted, Fiscal Year (FY) 2010) indicated that there were total of 173 nursing positions, of which 106 were Registered Nurses (RNs) and 67 were Licensed Vocational Nurses (LVNs) budgeted, with three vacancies. It was not clear from the report what level of nurses (RN or LVN) were vacant. At the last compliance review the Facility reported 112 RN and 67 LVN positions were budgeted. Comparison between these budgeted figures shows a reduction of six RNs. The reduction of RN staff was of concern regarding the Facility's ability to provide adequate nursing care and to meet the requirements set forth in the Settlement Agreement and Health Care Guidelines. The Nursing Department was not using agency nurses to supplement nursing staff. The Nursing Department reported there was one Nurse Manager for each Living Unit. There was an average of four Nurse Case Managers per unit, that is, one per each of the four dorms with an average of 16 to 20 individuals per case load. The Infirmary had a Nursing Director and one Nursing Supervisor. As of 4/10/11 the Minimum Staffing for Nursing Services included: • Facility-wide there was to be at least two RNs on duty every shift (the Nursing Department preferred three RNs), except during normal business hours, 8-5, M-F, when there were several RNs available on each unit. • Infirmary o One RN to every five Individuals each shift (1:4 if staffing permits) • Trinity o On the 6-2 shifts – four LVNs or any combination of LVNs or RNs o On the 2-6 shifts – three LVNs or RNs • Leon - On the 6-2 shifts and 2-6 shifts, two LVNs or RNs • Naches - On the 6-2 shifts and 2-6 shifts, two LVNs or RNs • San Antonio - On the 6-2 shifts and 2-6 shifts, two LVNs or RNs (The Nursing Department preferred three nurses, when extra personnel were available to overlapping days) • Three Rivers and Four Rivers - On the 6-2 shifts and 2-6 shifts; two LVNs or RNs (prefer three, when extra personnel are available on overlapping days). The Monitoring Team requested the staff nursing ratios to individuals for each Living	

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		Unit by shift but the information was not received. What was provided was the ratio of nurses to individuals for the total nursing staff, including administrative, management, and clinic nursing staff over a 24 hour period. The budgeted information contained in the document request indicated a 1:2.25 ratio for nursing staffing. While on the surface this ratio may appear adequate, it fails to account for the actual ratio of staff nurses to individuals. Therefore, it was not possible for the Monitoring Team to make a determination regarding adequacy of nursing staffing based on the ratio of staff nurses to individuals for each Living Unit by shift. After the restructuring of the nursing staff the Nursing Department should evaluate the ratio of nurses to individuals based on level of individuals' acuity in each Living Unit by shift to ensure adequate coverage of staff nurses. The nursing staffing patterns remained the same as at the last compliance review. With the exception of Trinity and the Infirmary, the 10-6 shifts for the other Living Units were covered by the Campus RNs based out of the Infirmary. It was of concern that there remained no full-time nursing coverage on the 10-6 in these Living Units. Because of the lack of full-time nursing coverage on the 10-6 shifts in Leon, Neches, San Antonio, Three Rivers, and Four Rivers, it is imperative that the Nursing Department thoroughly train the direct care professional staff to recognize, respond and report basic signs and symptoms of changes individuals' health status to the nursing staff. Additionally, one of the Infection Control Nurses reported that her position was being eliminated in the next few weeks. Refer to the Infection Control Program section of this provision for concerns related to the potential impact the loss of this position may have on the performance of the Infection Control Program. The Nursing Department needs to continually retain, recruit, and evaluate the need for additional staffing and other resources to meet the increasing health needs of individuals served. <u>Quality Assurance Efforts</u> Since the last review the 21 Nursing Monitoring Tools were revised and reduced by the State Office to 12 more user-friendly versions. Interpretive Guidelines were developed for each of the Nursing Monitoring Tools that identified specific criteria that constituted compliance with each item on the tool as well as ensuring that all monitors are consistent in evaluating data. The Facility began using the revised Nursing Monitoring Tools on 1/4/11. The revised tools included: 1. Nursing Care: Acute Illness and Injury 2. Nursing Care: Annual Nursing Assessment and Quarterly Nursing Assessment combined 3. Nursing Care: Documentation 4. Nursing Care: Infection Control 5. Nursing Care: Management of Chronic Respiratory Distress	

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		6. Nursing Care: Medication Administration and Documentation 7. Nursing Care: Annual Nursing Care Plans, combined the following Care Plans: a. Psychotropic Medications b. Bowel Management c. Hypertension d. Gastroesophageal Reflux (GERD) e. Aging f. Incontinence and Urinary Tract Infections g. Diabetes 8. Nursing Care: Pain Management 9. Nursing Care: Prevention 10. Nursing Care: Seizure Management 11. Nursing Care: Skin Integrity Assessment 12. Nursing Care: Urgent Care/Emergency Room Visits, and Hospitalizations Since the last compliance review it was evident the Quality Assurance Department had continued to refine their procedures and processes for conducting audits using the 12 revised Nursing Care Monitoring Tools. It was positive to find a formalized schedule of assignments and timelines for completion of the audits as well as the implementation of procedures for conducting inter-rater reliability checks. The procedures and/or processes used to select and assign audit samples are described below: • The Quality Assurance Nurse trained the Nursing Administration Nurses, Nurse Managers, and Nurse Case Managers on the use of the Nursing Care Monitoring Tools. • There are 12 Nursing Care Monitoring Tools. The Nursing Care Monitoring Interpretative Guidelines provided instruction for selecting the sample for each tool. • The Quality Assurance Nurses selects the records to be audited each month. A monthly schedule was prepared. • The Quality Assurance Nurses, with input from the Chief Nurse Executive, assigned each Nursing Administration Nurse, Nurse Manager, and Nurse Case Manager the Nursing Care Monitoring Tools to audit. A total sample size of 96 tools was assigned, eight per each of the 12 types of tools. • Each RN entered the completed tools into the Quality Assurance Database. • The Quality Assurance Nurses selected one tool from each of the 12 Nursing Care Monitoring Tools to audit for inter-rater reliability. The Monitoring Team reviewed Quality Assurance data provided through the document request. It was apparent that review of the data generated for the revised Nursing Care Monitoring Tools could not be compared to previous data because of the changes made	

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		to the tools. The data reviewed from the 12 Nursing Care Monitoring Tools, 1/2011, 2/2011, and 3/2011, were represented in a graph for each month. The data were too preliminary to draw accurate conclusions regarding the outcome of findings because the nurses were familiarizing themselves with the use of the revised tools as were the Quality Assurance Nurses with the inter-rater reliability process. Additionally, of the projected 96 audits, not all of the tools were completed by the assigned nursing staff. Review of the Quality Assurance data for completing monitoring tools per month indicated that three tools were completed in January 2011, 53 in February 2011, 65 in March 2011, and 86 in April 2011. Further, when comparing the scoring results on the monitoring tools completed by the nursing staff to the Quality Assurance Nurses' inter-rater reliability checks, there was wide disparity in agreement identified between the results in almost all of the 12 monitoring tools audited. The Quality Assurance Nurses' inter-rater reliability checks for the tools monitored by the nurse should consistently be at least 80% or more to demonstrate confidence in their data. In order for the Facility to have an effective and reliable Quality Assurance System for monitoring nursing's compliance with the Nursing Care Monitoring Tools, the Quality Assurance Department and Nursing Department must ensure that the monthly assigned monitoring tools are completed; and identify and reconcile the reason for the wide disparity between the monitoring results obtained by the Quality Assurance Nurses and the nursing staff. There was documented evidence contained in the completed Nursing Care Monitoring Tools that demonstrated that the Quality Assurance Nurses were beginning to analyze the available data and take immediate corrective action with individual nurses when deficiencies were identified on the monitoring tools; there had not yet been corrective actions on systemic issues. Written reports of any deficiencies identified and corrective action taken were sent to the Chief Nurse Executive and/or other relevant disciplines. By the next compliance review the procedures and processes for auditing the Nursing Care Monitoring Tools and conducting inter-rater reliability checks should be refined and enough data available to begin to analyze, trend and identify systemic issues that require formalized corrective action plans. In addition to the Quality Assurance Nurses auditing the 12 Nursing Care Monitoring Tools, they also monitored other items that included: • AED Monitoring (included checking suction machines and oxygen tanks) o All AEDs on campus were monitored twice a year o Each AED was opened to verify that: the battery was working; the voice activation was working; the pads had not expired; if maintenance was needed; and if the daily checks were completed by the nursing staff. o The suction machines and oxygen tanks were checked and the equipment checklists completed by the nursing staff. • All Nursing Licenses – quarterly	

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		o All nursing licenses were checked monthly for three months (2/2011, 3/2011, and 4/2011), then will be checked quarterly o The licenses were checked ensure they were current and if there were any stipulations. o If stipulations were found they were printed and reviewed. o A written report was sent to the Chief Nurse Executive, Facility Director, and Quality Assurance Director. • All Medication Rooms – twice a year o All medication rooms on campus were inspected at least twice a year accompanied by the unit nurse. o The rooms were checked for: security; that medications were stored properly, e.g., that internal and external medications were separated, food items in the refrigerator were labeled with the date opened; medications were separated from food items; no personal food or drinks present; and refrigerator temperatures were monitored. • Positioning of individuals – periodically o Individuals were checked periodically for proper positioning to ensure that those with G/J tubes or Gastroesophageal Reflux Disease (GERD) were positioned properly according to their Physical and Nutritional Management Plans (PNMPs). o Positioning was also checked during medication administration observations. o If an individual was positioned poorly the direct care professional was immediately asked to reposition the individual. • Medication Administration Records – quarterly o Current Medication Administration Records (MARs) were checked quarterly to ensure all medication errors were identified. o If medication errors were found the medication nurse accompanying the Quality Assurance Nurses was advised as well as the Unit Nurse Manager. o The Narcotic Logs were checked for two signatures at each shift change. • Medication Administration Observations were performed using the standardized form – the frequency of the observations and sample sized was not made available for review. While there were no trend analysis data available for the above items monitored, there was documented evidence that the Quality Assurance Nurses took corrective action when deficiencies were identified and written reports were sent to the Chief Nurse Executive and/or other relevant disciplines. It will be important for the Facility to track and trend findings in order to identify issues needing systemic improvement.	

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		According to the Facility's Plan of Correction Report, 4/18/11, for Section E, the RSSLC Management expressed the need for the Quality Assurance Nurse to follow up on the Monitoring Team's Nursing Recommendations to ensure that they were becoming compliant with the Settlement Agreement. The Facility Management Team believed many of the recommendations could be met through in-service training. The Quality Assurance Director recommended that the Quality Assurance Nurse develop a comprehensive in-service for the nursing staff to address the Monitoring Team's Nursing Recommendations. There was documented evidence that the Quality Assurance Nurse provided mandatory/competency-based training on the Monitoring Team's Nursing Recommendations to 168 of the 177 (95%) nursing staff. Training for the remaining nurses was projected to be completed on 5/25/11. Providing the competency-based training on the Monitoring Team's Nursing Recommendations to the nursing staff was a good first step in responding to the recommendations but ensuring compliance with the recommendations cannot be achieved by a one-time training of the nursing staff. Verification that the recommendations were carried out can only be accomplished when they translate into actual practice that can be identified by the Monitoring Team. Further, it is important that the Facility recognize that compliance with the Settlement Agreement and Health Care Guidelines must not be solely limited to recommendations made by the Monitoring Teams at the time of the compliance reviews. Therefore, in order to achieve compliance, the Facility's Management team and all relevant disciplines must have a thorough understanding of the requirements set forth in all sections of the Settlement Agreement and Health Care Guidelines. Since the last compliance review the Nursing Department reported they had made a concerted effort to improve all aspects of documentation. The Monitoring Team was provided with their Documentation Audit Process. Each unit maintained a "Book" containing a specific log sheet for the documentation to be audited. Each form of documentation had a specific audit tool. The Nursing Administration, Nurse Managers, and staff nurses review each "Documentation Book" on a monthly basis as a peer review. When documentation errors were found the respective Nurse Managers took the documentation audited to their respective nurse(s) for counseling and retraining. The Documentation Audit Process included auditing documentation on Acute Care Plans, Medical Monitoring, Neurological Assessment Protocols, and associated documentation requirements. The Documentation Audit Process is described below: • For new Acute Care Plans, Medical Monitoring, and Neurological Assessment Protocols the nursing staff completes the following functions: o The RN will develop an Acute Care Plan or initiate Medical Monitoring or Neurological Assessment Protocol. o The RN will log in the Acute Care Plan or initiate Medical Monitoring or Neurological Assessment Protocol on the appropriate login sheet.	

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- The RN will compete the documentation initiation box on the appropriate colored sheet:
  - Green for Acute Care Plan
  - Orange for Medical Monitoring Form
  - Pink for Neurological Assessment Protocol
- After completion of the colored sheet, make a copy and place the copy in the Documentation Book.
- Place the colored sheet in front of the Medication Administration Record.

- Daily Documentation:
  - Each nurse will document each shift in the Integrated Progress Notes any follow-up and/or changes in health status and initial the appropriate task, after completion on the colored sheet in front of the Medication Administration Record.
  - The Nurse Case Manager will document in the Integrated Progress Notes the notification to the Personal Support Team and initial the "Notification of Personal Support Team" space on the colored sheet.
  - Copies of the previous day's documentation will be made and forwarded to the Nurse Manager for review.
  - The Nurse Manager will audit each Integrated Progress Note entry and record any findings on the Documentation Audit Form.

The Nursing Department analyzed and trended the number of documentation errors resulting from the Documentation Audit data, by unit and by month. The data were represented in a bar chart for 12/2010, 1/2011, 2/2011, and 3/2011 for each unit's number of documentation errors. The data represented below will be used as a benchmark for comparison at future compliance reviews:

Documentation Errors Reported through Audits

Unit	December	January	February	March	Overall percentage of decrease comparing December to March
3 Rivers	127	120	171	102	
4 Rivers	149	98	13	15	
San Antonia	429	445	259	175	
Trinity	243	251	195	95	
Neches	76	86	67	55	
Leon	323	326	195	110	
Total Errors	1347	1326	900	552	41%

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		It was positive to find that the Nursing Department had self initiated a process for improving documentation. It was impressive that this initiative had resulted in a 41% decrease in documentation errors for the documentation items audited. The Nursing Department should continue to conduct documentation audits and ensure that the documentation reflects the quality and effectiveness of the nursing care rendered. The Nursing Department reported they complete audits on other nursing items. The Monitoring Team was provided a description and blank audit form for each item audited that described what was audited, by whom, frequency, and sample size. The descriptions failed to describe by whom or how the data derived from the audits were analyzed, deficiencies identified and corrective action taken. Other items monitored and the processes used by the nursing staff are listed below. • Each Nurse Manager assigns an either a RN or LVN to check equipment daily. Each unit's Nurse Manager reviews one checklist per month for each of the following types of equipment: AEDs, Suction Machine, and Refrigerator Temperature Log. • Each Nurse Manager audits documentation on every RN and LVN monthly. • Each Nurse Case Manager observes two medication passes per month (one per shift per caseload). • The Infirmary the Charge Nurse, for each shift, completes a medication pass observation on each nurse on their weekend rotation. Sample size audited is one per week. Refer to Section M.6. • The Medication Administration Signature Sheets contained in each Medication Administration Record Binder are reviewed every shift by either the RN or LVN to ensure all nursing staff administering medications has their signatures on the Signature Sheets. Each Nurse Manager audits one Medication Administration Record Binder per month per unit. • A second signature on the monthly Medical Administration Record Checklist is reviewed monthly by the either the RN or LVN. Each Nurse Manager audits one Medical Administration Record Checklist per month per unit. Refer to Section M.6. • A second signature on the Physician's Orders is reviewed by the either the RN or LVNas orders are transcribed. Each Nurse Manager audits one set of Physician's Orders per month per unit. Refer to Section M.6. • A second signature on Quarterly Orders are reviewed by the either the RN or LVNquarterly. Each Nurse Manager audits one set of Quarterly Orders per month per unit. Refer to Section M.6. • Each Nurse Manager inspects Medication Rooms once a month. Each Nurse Manager audits one Medication Room per month per unit, as applicable. Refer to	

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		Section M.6. • The Empty Medication Vials Pharmacy Shortage/Coverage Forms (if any injectable medications were used, this form is completed and the empty vial sent to the Pharmacy). These forms are completed by the either the RN or LVN. Each Nurse Manager audits one Empty Medication Vials Pharmacy Shortage/Coverage Form per month per unit, as applicable. • The Hospital Transfer Checklist is completed by either the RN or LVN when individuals are transferred to the hospital. Each Nurse Manager audits one Hospital Transfer Checklist per month per unit, as applicable. The Nursing Department did not provide the Monitoring Team with a summary of the data derived from these items monitored. This monitoring data needs to be aggregated and summarized into a useful format to analyze, trend, and take corrective actions on identified deficiencies. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last compliance review the Nursing Department had made a concerted effort to improve the quality of documentation by developing and implementing a comprehensive Documentation Audit process, as described above. In addition, because of delay by the nurses to promptly notify physician of individual changes in health status, the Facility had developed and implemented an On-Call Medical Guidelines, Date: 4/8/11. As a result, the reviews of the Integrated Progress Notes were showing progressive improvement. The most significant improvement was the almost consistently use of the Subjective, Objective, Assessment, Plan, and Evaluation (SOAP) method of charting. Acute illnesses and injuries were almost always followed through to resolution. It was positive to find that the entries for acute illnesses and injuries also stated whether the problems were not resolved. Acute illnesses and injuries were more consistently followed-up according to protocol. The acute illnesses and injuries notes also contained instructions for the direct care professionals to contact the nurses if there was a change in individuals' health status and other special instructions when applicable. Although the general quality and documentation method of charting had improved there remained some issues that need to continue to improve. Problematic issues identified in records reviewed for Individuals #174, #479, #481, #6, #797, #573, #442, #223, #264, #375, #348, #134, #740, #415, #632, #385, #149, #363, #498, #235, and #267included: • Many nursing progress notes and signatures and titles continued to be illegible. • Integrated Progress Notes written by all disciplines were not consistently written in chronological order. • Unapproved abbreviations continued to be used occasionally. • The method that temperatures were taken was not consistently documented. • There was no indication if oxygen saturations documented were reflective of	

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		room air or with use of oxygen. • There was a lack of specific description regarding size and appearance of wounds or injuries and their exact location. • Follow-up from issues noted in previous nurses' progress notes was inconsistent. • There was a lack of adequate updated Health Maintenance Plans to reflect changes in individuals' health status and new interventions. • There was a lack of assessment and documentation of bowel sounds and palpation of the abdomen for individuals with constipation and receiving per necessary laxatives, suppositories, or Fleets enemas. • Lung sounds were not routinely assessed and documented for respiratory issues. • There was a lack of analysis of contributing factors impacting change of health status. • Records continued to reflect a lack of urgency in contacting the physicians when there was a change in individuals' heath status. Examples of findings from review of individuals with acute illnesses: • Individual #267: On 4/3/11 at 1:30 p.m., Individual #267 was observed by the nurse sitting in bed and smacking lips and laughing. The nurse reported that the individual seemed agitated. Vital signs were taken and revealed a temperature of 97.3, pulse 138 beats per minute, respirations 20 breaths per minute, blood pressure 104/64 and oxygen saturation of 95%. No other nursing assessments were completed. At 1:45 p.m. the physician was notified of findings. At 3:35 p.m. the physician returned the phone call and upon the nurse's report ordered Individual #267 sent by ambulance to the hospital to rule out a pulmonary embolism. The nurse called the ambulance service. A complete nursing assessment was completed before Individual #267 was transported to the hospital at 5:45 p.m. The nurse made a nurse to nurse call to the emergency room and gave a report. The nurse made all the required notifications to the Facility staff and parent. There was no documentation that the transfer information was sent to the hospital. Individual #267 was discharged on 5/4/11 from the hospital with discharge diagnoses of tachycardia and Urinary Tract Infection. Upon return home the nurse performed a complete nursing assessment. An Acute Care Plan was developed and implemented and the direct care professionals were trained. No further documentation was made available for off-site review. It was of concern on 4/3/11 at 1:30 p.m. when Individual #267 was observed with a change in health status that the nurse did not perform a complete nursing assessment, including lung and bowel sounds, in order to ascertain the best possible clinical picture of Individual 267's status. Having a	

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		complete nursing assessment is vital in providing the physician with pertinent information upon with to make decisions regarding the urgency for medical intervention. It was of concern that the nurse made no further attempts to contact the physician and that the physician did not return the nurses' phone call for almost two hours, particularly with Individual #267 having a pulse rate of 138 beats a minute. It was of concern that there was a delay of four hours before Individual #267 was sent to the emergency room for care, particularly after being sent to rule out a pulmonary embolus, which is a potentially life threatening condition. Fortunately, it was determined that Individual #267 did not have a pulmonary embolus. It was further concern that on 4/2/11, Individual #267 had an episode of aggressive behavior that required a basket hold restraint. It is plausible to wonder if the maladaptive behavior was related to the onset of the Urinary Tract Infection. The Nursing Department needs to ensure that nurses perform a complete nursing assessment on individuals for underlying changes in health status when individuals engage in atypical maladaptive behaviors as well as when there are any changes in health status. The nurses need to promptly notify the physicians and thoroughly describe the assessment findings. If the physicians do not promptly return phone calls the nurses must continue to contact the physicians; if unsuccessful, the appropriate Facility authority should be contacted. However, if the individual's health status is determined to be an emergency, the emergency response system must be initiated. Individual #267: On 4/13/11 at 4:45 p.m., the direct care professionals reported to the nurse that Individual #267 had an open blister on the right lateral breast. The nurse assessed the right breast and found a ½ centimeter red raised area without drainage. The physician was notified of assessment findings. The physician assessed Individual #267's right breast on 4/14/11 and diagnosed an early soft tissue infection. The physician ordered Bactrim DS, orally, twice a day for 14 days and Hibiclens bath once a month. The Infection Control Nurse was notified of the breast infection. On 4/14/11 an Acute Care Plan was initiated and the direct care professionals were trained on the plan. There was documentation that the nursing staff consistently implemented the Acute Care Plan. Nursing assessments of the right breast were completed daily on the 6-2 shifts and 2-10 shifts from 4/14/11/ through 4/28/11. Assessments included assessments of the right breast for evidence of infection and healing, tolerance of the antibiotic therapy, and pain. The direct care professionals were reminded at each assessment to report any changes in health status to the nurses. Each assessment stated the problem was not resolved until 4/28/11 when Individual #267 was assessed by the physician who determined that the right breast was healed. Then, the nurse wrote a resolution note and informed	

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		the Infection Control Nurse of the resolution of the infection. Concerns identified in review of the documentation included: Failure of the nurses to document the size and actual description of the wound. The nurses did document whether there was swelling and/or drainage of breast tissue at the wound site. Vital signs were not consistently assessed each time. When temperatures were taken the method was rarely documented. When oxygen saturations were assessed it was not indicated if they were a result of room air or with oxygen use. Entries in the Integrated Progress Notes were not consistently written in chronological order. Although a few concerns were identified there was overall improvement in following the Acute Care Protocol. • Individual #375: While the Monitoring Team was touring the Infirmary on 5/4/11, Individual #375 was observed resting quietly in his bed. He was receiving care in the Infirmary since 5/1/11 after having been treated in the emergency room for a Urinary Tract Infection. The Monitoring Team interviewed the direct care professional caring for Individual #375. When he was asked what needed to do for Individual #375, he responded that the nurse had instructed him to observe Individual #375's bowel movements and to assist with feeding. When asked about Individual #375's positioning he replied that positioning would be changed about every 45 minutes. The direct care professional said he knew the Individual from the unit but that his Program Book and wheelchair had not been brought over to the Infirmary. It was apparent the direct care staff had not been instructed by the nurse in Individual #375's care. Individual #375 had been in the Infirmary for three days and should have had his Program Book, wheelchair and any other adaptive equipment brought to the Infirmary. He had a PNMP with a plan for side lying and supine lying positioning and a tilt in space wheelchair. According to the Individual #375's Physician's Orders, there was no restriction on his ability to be out of bed and his PNMP followed. The PNMP was not sent to the Infirmary. It was a concern that the Program Book, PNMP, and adaptive equipment were not sent by the unit to the Infirmary nor had the Infirmary requested those items. Active treatment should be continued in the Infirmary, unless there is a medical order that restricts active treatment. In Individual #375's situation that did not appear to be the case. • Individual #134: Individual #134 had diagnoses of COPD, Pulmonary Restrictive Disease, Congestive Failure, and Hypertension. On 5/2/11 at 2:30 p.m. the LVN reported to the RN that Individual #134 was complaining of shortness of breath, and was anxious and was breathing fast. The RN told him to relax and breathe slowly. Vital Signs were assessed as temperature 96.3, pulse 83 beats per minute, respirations 26 breaths per minute, blood pressure 138/71, and oxygen saturation 99% with 2 liters of oxygen. The Respiratory staff were present and gave a nebulizer treatment which was tolerated but lung sounds were noted.	

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		The nurse did not complete an assessment of the lungs sounds by auscultation. The nurse called the physician's cell phone and left a message, then awaited the phone call. The physician did not return the phone call and the nurse did not follow-up with further efforts to contact the physician. The nursing note at 4:00 p.m. stated that Individual #134 said he felt better after the nebulizer treatment. There were no further assessments documented until 5/3/11 at 6:15 a.m. when the LVN reported Individual was wheezing and had a nonproductive cough. The RN assessed respiration rates of 20 – 30 breaths per minute. An Albuterol nebulizer treatment was administered. Vital signs were assessed as temperature 96.6, pulse 93 beats per minute, respirations 24 breaths per minute, and oxygen saturation 96%. The RN did not complete an assessment of the lungs sounds by auscultation. The nurse called the physician and at 7:00 am; the physician returned the call and referred Individual #134 to morning Sick Call. Around 10:00 a.m. Individual #134 was taken to the bathroom by wheelchair. Upon return from the bathroom the short of breathiness and wheezing began again. Vital signs were assessed as temperature 98.3 auxiliary, pulse 105 beat per minutes, respiration 32 breaths per minute, blood pressure, and oxygen saturation 98%. Individual #134 was seen by the physician at 10:15 a.m. By the time he was assessed by the physician his respiratory status had progressively worsened with acute COPD exacerbation. An ambulance was called and he was sent to the emergency room at 10:50 a.m., where he was later admitted. The transfer order was sent to the emergency room with Individual #134. A nurse to nurse call report was given to the emergency room nurse. All required notifications to the Facility personnel and the guardian were made. It is plausible to wonder if on 5/2/11 at 2:30 p.m. the nurse had been more assertive in contacting the physician and pursuing prompt medical attention at the onset of change in respiratory status, could the acute COPD exacerbation been avoided or at least minimized. The Nursing Department needs to ensure that nurses receive training on assessing and managing the care of individuals with COPD and Restrictive Airway Disease. Refer to Section L.2 for additional information regarding Individual #134. <u>Skin Integrity Issues</u> It was positive to find that the Nursing Department continued to retain a Certified Wound Care Nurse. The Wound Care Nurse continued to chair monthly, and when needed, Skin Integrity Committee Meetings. The Committee serves as an integrated forum to review all types of skin integrity issues. The membership consisted of Quality Assurance Nurses, Nutritionist, Medical Director, Unit Physicians, Infection Control Nurse, Habitation, Unit Director, Pharmacist, Unit Director, Nurse Managers, Nurse Case Managers, and other relevant discipline staff. The Nurse Case Managers present any individual who has diagnosed skin integrity issues. Review of the Skin Integrity	

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		Committee Meeting Minutes discussed problems that contributed to skin integrity issues and made recommendations for solving problems. The Monitoring Team reviewed Skin Integrity Committee Meetings, 11/10/10, 11/17/10, 11/24/10, 12/8/10, 12/29/10, 1/12/11, 1/26/11, 2/2/11, 2/16/11, 2/23/11, 3/9/11, 4/6/11, and 5/4/11. This Committee performed in the most integrated manner of any of the committees the Team Member had reviewed. It was positive to find that at the time of the compliance review the Facility did not have any active pressure sores. The Wound Care Nurse continued to maintain a Decubitus Tracking Report by the month. The tracking report included whether pressure sores were acquired at the facility or were hospital acquired. The tracking report failed to analyze and trend pressure sore data. The Wound Care Nurse needs to develop and implement a trend analysis to identify systemic skin integrity problems so that corrective action plans can be established and implemented to prevent or minimize skin integrity issues. Review of Individual #573's Integrated Progress Notes and other related documents 12/22/10 through 2/22/11 demonstrated integrated efforts put forth by the PST in the healing of Individual #573 multiple pressure sores. Individual #573 returned to the Facility from a long stay at a Long Term Acute Care Facility with a stage three pressure sore on the right buttock, a stage four pressure sore on the left hip, and an unstageable pressure sore on the right lateral foot. Because of the collaborative interventions of the PST, Individual #573's pressure sores were healed by 2/22/11. The individual continued to have a Health Maintenance Plan in place to prevent further skin integrity issues from developing. Review of Individual #175's Integrated Progress Notes and other related documents, 11/2010 through 5/2011 indicated that he had neurodermatitis resulting in periodic episodes of excoriation and cellulitis. Individual #175 had chronic abrasions of bilateral shins; they would heal and then break down again. There was documented evidence that the nursing staff applied prescribed treatment daily to the shins and assessed the wound at least twice a day. The wound size and appearance was rarely documented but the nurses did consistently document whether there was drainage or signs and symptoms of infection and if the wounds were healing. The nurses almost consistently documented assessment and nursing care rendered using the SOAP formation for charting. There was consistent documentation that the nurses instructed direct care professionals to report any change in health status. There was consistent documentation with each entry as to whether the wounds were resolved. These were positive findings since the last compliance review. Interview with the Infection Control Nurse indicated that Individual #175's wound management was reviewed at the Skin Integrity Committee on 5/4/11; the Committee recommended protective shin splints to assist in healing and to prevent	

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		further abrasions of the shins. She reported that Individual #175 likes to sit in front of his open wardrobe and listen to his music while rubbing his shin against the drawers. Reportedly this practice causes abrasions to the shin. She reported that the Behavior Analyst had attended the meeting for the first time. The decision as to whether protective shin splints could be used has to go to the Human Rights Committee and PST for approval. <u>Infection Control</u> At the time of the compliance review the Facility had two Infection Control Nurses, who reported to the Nursing Department. One of the Infection Control Nurses stated she would be resigning the next week and that the position would be eliminated. There had been no additional clerical staff added as was recommended at the last compliance visit. Clerical staff was recommended to assist in populating the Infection Control Database and to enter current data. This assistance would have freed up the Infection Control Nurses to use their expertise in providing clinical services, e.g., gathering, analyzing and trending infection control data, follow-up on outbreaks of contagious diseases, preparing and sending required infectious disease reports to the Department of Health, chairing the Infection Control Committee, serving as a consultant to nurses, physicians, pharmacist, and other health care disciplines, monitoring of infectious diseases, environmental surveillance, handwashing and standard precautions practices, and staff education. The potential loss of an Infection Control Nursing position was of significant concern because of the complex and multifaceted responsibilities inherent in providing a high quality and effective Infection Control Program at the Facility. The loss of the second Infection Control Nurse has the potential to cause a negative impact on the Infection Control Program. At the last compliance visit the Infection Control Program had developed an excellent and comprehensive Infection Control Database. This database had the capacity to run a variety of complex and detail Infection Control Reports for which the data derived from the reports provided vital clinical information for decision making in order to track, analyze and trend infections, immunization status, and other significant infection control indicators. According the Infection Control Nurses, the Infection Control Database had not been completely populated and they were behind in entering current data due to the lack of time and human resources. An Immunization Database to track all individuals' immunizations was recommended at the last compliance visit. The Immunization/Vaccination Database was created but was not completely populated. This is an important database to assist nurses and physicians track immunization status of individuals to ensure immunizations are up to data. Future plans were to enter: Hospital reports to track infections acquired during hospitalization; sensitivity rates from the lab results extrapolated from antibiograms; and possible sources of infections. The Facility should ensure that the Infection Control Program is adequately staffed with	

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		Infection Control Nurses and support staff to maintain a high quality and effective Infection Control Program. The Infection Control Nurses continued to track and report the basic areas of infection surveillance of: MRSA; Hepatitis A, B, and C; positive Tuberculin Skin Tests; HIV; STDs; immunizations; and antibiotic use. The infection Control Program did not have a formalized procedure for conducting reliability checks on the infection data reported. The Infection Control Nurse explained that she cross-checked data by reviewing Infection Reports completed by the nursing staff, Pharmacy Antibiotic Reports, Lab Reports, X-ray Reports, and Sick Call Logs. These data were collected weekly. The Infection Control Program needs to develop and implement a formal system for checking the reliability and timeliness of the infection data reported to ensure that all infections are reported; and to identify any infectious trends that may be emerging that would require immediate attention. In 1/2011 there was an outbreak of Scabies in Trinity D and Neches C. There was evidence that the Infection Control Nurse in-serviced the staff in Trinity D and Neches C on Scabies. Isolation and standard precautions were put in place until the contagious period passed. The Infection Control Program needs to implement "real time" monitoring of acute infections to ensure that appropriate antibiotic therapy and precautions were being implemented and were effective. Due to the potential for infectious diseases to spread, monitoring this area needs to be conducted while the acute infections are active. Retrospective monitoring does not allow for immediate intervention and resolution of problematic issues. The Infection Control Nurse reported that the standardized Infection Control Policies and Procedures developed by the SSLC Infection Control Practitioner's workgroup were completed and that the Facility was in the process of operationalizing the policies and procedures. The Monitoring Team reviewed the quarterly Infection Control Committee Meeting Minutes for 1/10/11. There were no other quarterly Infection Control Committee Minutes available for review. The minutes reported the air quality in Trinity had improved. A trial was completed in the Trinity Dorm A with the installation of germicidal UVC (short-wave ultraviolet radiation, in the "C" band) emitters installed in the air handlers to kill mold, bacteria and viruses. The Maintenance Department reported that the blower compartment was internally covered with what appeared to be mold but after the installation the mold substance not longer existed. This was a positive finding since the Monitoring Team had expressed concern regarding what appeared to be mold	

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		growing out the ceiling tiles in Trinity, where individuals with the most medically complex issues reside. The Committee had recommended, in an effort to decrease infections in individuals, that programming should be brought to the homes when the outside temperature dropped below a certain degree but the higher administration did not agree. The Medical Director stated she would write orders to cancel on campus appointment during extreme cold weather. The minutes included a report of the first quarter FY2011 (September, October, and November) number of infections as listed below: • 7 – MRSA • 14 – Urinary Tract Infections • 5 – Upper Respiratory Infections • 32 – Lower Respiratory Infections (This number represented all diagnosed cases of lower respiratory infection including Aspiration Pneumonia and other types of pneumonias) • 3 - Gastrointestinal Infections The Monitoring Team's review of the accompanying Infection Control Trend Report indicated that the Infection Control Nurses were beginning to analyze and trend infection data by each type of infection, by quarter, by unit, by month, make comparisons of quarterly data, and identify probable causes. This was a positive step forward since the last compliance review. The next step should be for the Infection Control Committee to develop and implement preventative plans related to the probable cause of infections identified through trend reports to prevent or minimize their occurrences. The infectious disease data continued to be reported in numbers as opposed to rates. The infectious disease data needs to use a standardized methodology for calculating the rates of infections. Rates should be calculated for each living area and the Infirmary as well as for the whole facility. Rates should also include nosocomial and associated health care infection rates. According to the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC), "infection rates should be calculated monthly, quarterly, and annually. Analysis of absolute numbers of infections can be misleading. Health Associated Infections calculated rates provide the most accurate information. Rates are generally calculated by using 100 resident-days as the denominator. A standard infection report form facilitates reporting of surveillance information. Tables, graphs, and charts may be used and facilitate education of staff. Surveillance data should be used for planning infection control efforts, detecting epidemics, directing continuing education, and identifying individual resident problems for intervention. In addition to the collection of baseline infection rates, the Infection Control program should perform problem focus studies. Example, special studies for the evaluation of Urinary Tract Infections, a study of the occurrence of influenza in vaccinated versus unvaccinated	

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		residents, or the prevalence of pressure ulcers. In addition to the above outcome measures, surveillance should also include analysis of process measures relevant to infection control. Examples include monitoring hand hygiene compliance, observation of aseptic techniques, and measuring influenza vaccination rates." The Nursing Department should provide the Infection Control Nurse with the assistance of an Infection Control expert or formalized training in Infection Prevention and Control for Long-Term Care Facilities. The Infection Control Nurse Reported that 97% of the individuals had received the seasonal influenza vaccine. Three percent were refused by the individuals' guardians. Eighty-eight percent had received Tuberculin Skin Testing with negative results. Twelve percent of the individuals' received questionnaires due to histories of positive Tuberculin Skin Testing. There were no signs or symptoms identified in the questionnaires. The Infection Control Nurse Reported that only 28 % of the employees had received seasonal influenza vaccine through the Employee Health Clinic. It was unknown the number of employees who had been vaccinated through their primary care physicians. It was of significant concern that only 57% of the employees were in compliance with the Facility's Tuberculin Skin Test Policy. According to the Communicable Disease Center's 2008 report, Texas was reported as one of the top four states in the nation with the incidence of Tuberculosis. The Facility needs to ensure that all employees follow the Tuberculosis Skin Test Policy. The Infection Control Program had adopted and implemented in December 2010 two new monitoring procedures developed by the State Supported Living Center Infection Control Practitioner's Workgroup for Handwashing/Glove Use and Infection Control Monitoring procedures and tools. Raw data was made available from the new monitoring forms and it appeared that when deficiencies were identified that they were documented on the form and immediate corrective action was taken. There were no analyses and/or trend data available to review. Therefore, it was not possible to discern the degree of compliance with the implementation and outcome of the new tools. In order for the data derived from the Handwashing/Glove Use Form and Infection Control Form. For these data to be useful the Infection Control Nurse must aggregate, analyze, trend, and develop corrective action plans for identified deficiencies. The Monitoring Team observed multiple roosts of Purple Martins along the interior roof of the Facility breezeway with bird dropping along the walkway under the roosts. An individual in a wheelchair was observed rolling along the walkway. The Quality Assurance Nurse immediately had the dropping cleaned up. The staff reported that the Purple Martins were on the endangered species lists and could not be removed. This was a concern because of the health hazard and the potential for individuals as well as staff to	

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		come in contact with the droppings. Bird droppings have the potential to transfer a variety of zoonotic diseases, e.g., Histoplasmosis, Cryptococcosis, Salmonella, Psittacosis, and Avian Tuberculosis to humans. Individuals with poorly functioning immune systems, the elderly, and young children, must practice extreme caution around bird droppings. Transmission commonly occurs when humans inhale or ingest infected dropping particles. For example, this could occur if an individual was independently propelling their wheelchair, their hands could become contaminated with the droppings if they rolled through the dropping or if they walked through and got droppings on their hands when they take off their shoes, and then put their hands in their mouth. The Facility should ensure that walkways are kept clean and free of bird droppings. Staff cleaning the bird dropping should use standard precautions to avoid potential transmission of disease or the Facility should contact the local Department of Health's Environment Services for proper disposal. The Facility's Plan of Improvement stated they were not in compliance with provision and the Monitoring Teams concurs with their findings.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	According to the Facility's Plan of Improvement the Nursing Department reported the nursing staff had been trained and policies implemented on nursing assessments, identification of health care problems, notifying physicians of health care problems, monitoring, intervention, and appropriate recording of individual's health care status. Training remains ongoing as well as monitoring the progress of the nursing staff in identification of health care problems, notification of the physicians, and intervention as needed. Training since 10/2010 included: • 11/1/10 – In-serviced on Policy 010 Nursing Services which was implemented on 1/31/11; Notification of the Primary Care Provider (PCP) in a Timely Manner of any Changes in Condition; and Policy E-19 Weight of the Individuals. • 12/7/10 – In-serviced Nurse Case Managers on Individual Immunization Policy, F-03 Breast Exams Policy, and D-03a Menses Policy. • 12/09/10 – Quality Assurance Nurses gave a detailed in-service on documentation of the nursing assessments, including the summary of Health Maintenance Plans to all Nurse Case Managers. • 12/9/10 – In-serviced on Health Maintenance Plans and Acute Care Plans (how to identify health care problems), Annual/Quarterly Nursing Assessments, and Tardive Dyskinesia to all Nurse Case Managers. • 1/6/11 – In-serviced on Health Maintenance Plans and Acute Care Plans: Do not combine several risk factors, this is required for all medium and high health risks as well as chronic health conditions. Comprehensive Nursing Assessments including analyzing and summarizing data identified in the nursing diagnoses.	Noncompliance

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		The training material provided by the Nurse Educators failed to include a formalized competency-based curriculum for training nurses on completing Comprehensive Nursing Assessments. Developing competency-based nursing skills in this area is vital to providing high quality nursing services. Refer to Section M.4 for more discussion regarding nursing training. Since the last compliance review the Nurse Case Managers were consistently using the Comprehensive Nursing Assessment form for completing annual and quarterly nursing assessments. Through the use of this form, assessment of the quality and content of the assessments were beginning to show steady improvement; however, there were areas still in need of improvement. Nursing assessments are a dynamic, ongoing, and continuous process of collecting, evaluating, and communicating health information regarding each individual's needs. Nursing assessments are the foundation from which actual health care problems and high-risk potential problems/nursing diagnoses are identified. It is from this information that plans of care are developed and implemented to address, prevent, and/or resolve problems. The assessments summarize pertinent health data from which change and goal achievement can be measured. Therefore, health care plans whether acute or long term must be based on complete and accurate nursing assessments. The Annual and Quarterly Comprehensive Nursing Assessments were reviewed for the following 20 Individuals: #479, #481, #6, #797, #573, #442, #223, #264, #375, #348, #134, #740, #415, #632, #385, #149, #363, #498, #235, and #267. Review of Annual (including Admission and 30 day Assessments) Comprehensive Nursing Assessments found 21 of the 22 (96%) were completed according to their Personal Support Plan Schedule (PSP). The Annual Comprehensive Nursing Assessmentfor Individual #385 was completed almost two months late. Admission and 30 day nursing assessments were completed for Individuals #573 and #740. Quarterly Comprehensive Nursing Assessments were completed for 53 of the 57 (93%) individuals and were completed according to their PSP schedule. One Quarterly Comprehensive Nursing Assessment was completed late for each of the following Individuals: #223, #134, and #235. One Quarterly was missing for Individual #740. The Braden Scale to rate skin integrity risk assessments was completed on78 of the 78 (100%) Annual and Quarterly Comprehensive Nursing Assessments. Review found 78 of the 78 (100%) Annual and Quarterly Nursing Assessments were completed by RN Case Managers. Twenty individuals' Annual and Quarterly Nursing Assessments reviewed for the last six	

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		months were found to be completed on the revised Comprehensive Nursing Assessment form. Nursing assessments completed on the Comprehensive Nursing Assessment form contained more complete assessment information in Sections I through XI for components related to current active medical diagnoses, consults, diagnostic testing/screening, medication review, history and functional assessments, and in most of the summary sections for specific assessment components. These improvements did not translate into improving Section XI for the overall nursing summary. It was apparent that the Nurse Case Managers completing the nursing summary section were making a concerted effort to analyze and summarize the clinical data, but little progress was made in spite of the increased amount of data included in the summaries. The summaries contained statements from the nursing notes, sick call notes, results of labs and diagnostic tests, lists of medications and treatments received throughout the quarter. Many summaries contained statements such as the individual "has been in fair health this quarter," "had been medically stable this quarter," and "has enjoyed the best of health this quarter." These statements were subjective and did not describe the individuals' actual health status and should be avoided. There were varying formats used to write the summaries. Some used the Health Maintenance Plans as a format for writing the summaries, which resulted in describing the plans without describing the individuals' response to the plans or the effectiveness of the plans. Other summaries were written in running narratives that made it difficult to actually identify individuals' health status in relation to their health problems and interventions designed to address the problems. When new risk factors were identified or there was a significant change in health status after the completion of the quarterly or annual nursing assessments, the assessments were not revised to include the changes. Some Nurse Case Managers demonstrated more competencies in completing the assessment than others. Examples of findings from review of the Annual and Quarterly Comprehensive Nursing Assessments are listed below. This information will serve as a benchmark for future compliance reviews: • Individual #632: Review of the Quarterly Comprehensive Nursing Assessment on 2/4/11 demonstrated improvement in completing Sections I through Sections IX, except for vitals signs which documented a pulse rate of 125 beats per minute. There was no documentation in the summary section regarding the elevated pulse rate. Neither was the elevated pulse mentioned in Section XI. Section X listed the following nursing problems/nursing diagnoses: Aspiration Pneumonia/Chronic Aspiration Syndrome, Enteral Feedings via Gastrostomy Tube, Constipation, GERD, and Seizures. There were corresponding Health Maintenance Plans for each of the nursing problems/diagnoses. However, the	

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		Health Maintenance Plans were established on 6/16/10. The plans failed to include documentation that they had been reviewed/revised at the time of the quarterly and annual nursing assessments. The plans were written on the template used previous to the implementation of the Health Care Protocols for Developmental Nursing template. The plans should have been revised and the new template used. At Risk Assessments for Individual #632 were completed on 3/23/11 that identified: high risk for: Circulatory secondary to deep vein thrombosis; medium risk for: Choking, Constipation, Gastrointestinal Problems, Osteoporosis, Seizure, Skin integrity, Polypharmacy, Falls, and Fluid Imbalance. The Quarterly Comprehensive Nursing Assessment of 2/2/11 had not been updated to reflect the At Risk Assessments of 3/23/11. The nursing problems listed failed include the newly identified high risk factor for Circulatory and medium risk for Skin Integrity, Falls, and Fluid Imbalance. Health Maintenance Plans were not established for these risk factors. Section XI nursing summary statement described Individual #632 as "in good health this quarter." The summary failed to analyze the raw data and to state Individual #632's health status regarding the identified nursing problems, or whether he was improving, maintaining, or regressing toward established goals and objectives set forth in his Health Maintenance Plans. Neither was his progress compared to the previous quarter or annual assessments. The effectiveness of the plans was not evaluated. • Individual #267: Review of the Quarterly Comprehensive Nursing Assessment on 4/18/11 demonstrated significant improvement in completing Sections I through Sections IX, except for documenting the status of Varicella vaccination or documentation of immunity. Section X listed the following nursing problems/nursing diagnoses: Ineffective breathing patterns related to compromised pulmonary function, Decreased lung expansion, Risk of aspiration related to entry of gastric contents into respiratory tract and enteral feeding, Risk for injury related to lack of activity and neuromuscular disorder, Risk for falls related to non-ambulatory status and neuromuscular disorder, Risk for decreased cardiac output related to history of high cholesterol levels, and Risk for constipation related to medications and physiological factors. There were corresponding Health Maintenance Plans for each of the nursing problems/diagnoses established on 4/18/11. At Risk Assessments were completed on 2/7/11 that revealed Individual #267 was at: high risk for: Weight (underweight) and Osteoporosis; medium risk for: Aspiration, Respiratory Compromise, Cardiac Disease, Circulatory, Constipation,	

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		Gastrointestinal Problems, and Challenging Behaviors. The nursing problem/nursing diagnoses failed to list the risk for weight risk or to have a Health Maintenance Plan for underweight. Individual #267's desired weight range was 100 to 130 pounds. Individual #267's weight was 120 pounds at the annual nursing assessment, 9/21/10, with a body mass index of 23 kg/2. At the time of this quarterly nursing assessment, 4/18/11 her weight was 102.8 pounds with a body mass index of 17.3 kg/2. This represented approximately a 15% weight loss. The Nurse Case Manager summarized the weight loss in Section IV, Nutrition and Weight Management and explained that Individual #267 was within her desired weight range. The fact that she was within her desired weight range does not negate the need to identify the apparent unplanned weight loss as a nursing problem and to develop and implement a Health Maintenance Plan. Section XI Nursing Summary included a list of Sick Call visits and their purpose for the past two quarters. The summaries were written based on the Health Maintenance Plans with an attempt to summarize each nursing problem/nursing diagnosis. Each nursing problem was reported to have no problems for the quarter. Although the summary sections in Section I through IX were well summarized it did not assist the Nurse Case Manager in analyzing and summarizing the nursing problems/nursing diagnoses. The summaries failed to compare the health status of each problem to previous quarters, to indicate whether Individual #267's health status was progressing, maintaining or regressing toward established goals and objectives. The effectiveness of the Health Maintenance Plans was not addressed. There was no mention of Individual #267's weight status. The nursing summary primarily consisted of listing health problems, diagnostics testing, and treatment regiment. The nursing summary stated the following Health Maintenance Plan Summary: • *Individual #267's health status has remained fairly stable this quarter with no hospital or infirmary admissions.* • *Risk of aspiration – Individual #267 had no incidents of aspiration this quarter. She is at high risk due to GERD and her enteral feedings. She is on Nexium 40 mg daily and receives her feedings with the head of her bed elevated or seated in a chair. She is also on GERD precautions. A chest X-ray was completed on 4/6/11, no lung infiltrates seen.* • *Risk of falls – No record of falls this quarter. She is at risk due to her non-ambulatory status, right sided hemiplegia, and low Vitamin D level. She is mobilized in a wheelchair with a gait belt for all transfers. She also has a brace on the right lower leg and foot. She is receivingVitamin D 3000 units daily.*	

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		• *Risk for decreased cardiac output – Individual #367 had had no cardiac problems this quarter. She is at risk due to her history of high cholesterol. She is receiving Atovastatin 10 mg and her lipid panel is within normal limits.* • *Risk for constipation – No reports of constipation this quarter. She is receiving Golytely 100 ml daily.* • *Risk for ineffective breathing – No reports of respiratory problems this quarter. She receives Albuterol and Ipratropim nebulizer treatments TID. She is at risk due to lung scarring from recurrent aspiration syndrome.* • *Risk for injury – She received no serious injuries this quarter. She is at risk due to lack of activity and right sided hemiplegia.* The Nurse Case Manager failed to indicate that the Comprehensive Nursing Assessment was provided to the Qualified Mental Retardation Profession (QMRP) or other relevant PSP members. • Individual #415: Review of the Quarterly Comprehensive Nursing Assessment on 2/8/11 demonstrated some improvement in completing Sections I through Sections IX, except for documenting the status of Varicella vaccination or documentation of immunity. Section X listed the following nursing problems/nursing diagnoses: Weight, less than body requirements related to reduced intake in relation to metabolic needs; and Psychotropic medication, risk for extrapryamidal symptoms. There were corresponding Health Maintenance Plans for each of the nursing problems/diagnoses established on 4/18/11. At Risk Assessments were completed on 4/7/11 that revealed Individual #415 was at high risk for Dental and medium risk for Choking. The nursing assessment had not been revised to include the risk for choking or a Health Maintenance Plan for Choking. The summary failed to compare the health status of each problem to previous quarters or to indicate if Individual #415's health status was progressing, maintaining or regressing toward established goals and objectives. The effectiveness of the Health Maintenance Plans was not addressed. • Individual #134: Review of the Quarterly Comprehensive Nursing Assessment on 3/24/11 demonstrated significant improvement in completing Sections I through Sections X.	

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		Section X listed the nursing problems/nursing diagnoses with an excellent description of the rationale for each: Osteoporosis: Risk for falls/injuries related to loss of integrity of the bone structure, decreased muscle strength/control, musculoskeletal disorder as evidenced by DEXA report on osteoporosis of left hip (trochanter) on 9/2/08, use of wheelchair for long distant travel secondary to Osteoporosis, Congestive Heart Failure, and Diabetes Mellitus. Skin Integrity: Risk for impaired skin integrity related to loss of pain perception in extremities secondary to diabetes. Hypertension/Congestive Heart Failure: Decreased cardiac output related to inadequate blood pumped by the heart to meet metabolic demands of the body as evidenced by occasional complaint of shortness of breath, decreased Left Ventricular Ejection Fraction (LVEF) of 50% per Echogram on 4/17/09, deep breathing. Diabetes Mellitus: Risk for ineffective tissue profusion peripherally related to impaired arterial circulation. Risk for impaired skin integrity related to loss of pain perception in extremities. Risk for infection related to altered metabolic state, impaired healing, circulatory changes secondary to hyperglycemia. Risk for injury related for infection related to fluctuation in blood glucose secondary to hypoglycemia and/or hyperglycemia. Ineffective management of therapeutic regimen. Diet and Nutrition: Risk for imbalanced nutrition, more or less than body requirements related to intake of nutrients either exceeds or insufficient to meet the metabolic needs as evidenced by fluctuations of weight outside the desired range (115 – 150 pounds). Pulmonary Restrictive Disease, Allergic Rhinitis, Asthma, COPD, and GERD: Risk for impaired gas exchange related to ventilation-perfusion inequality as evidenced by chest x-ray results. CT-Scan report, deep breathing secondary to COPD, Asthma, and GERD. Risk for ineffective airway clearance related to bronchi-constriction, increased mucus, muscular dysfunction and reflux of gastric contents into esophagus and tracheal or bronchial tree as evidenced by deep breathing, and barrel chest secondary to COPD, GRED, Asthma, and Kyphoscoliosis. There were corresponding Health Maintenance Plans for each of the nursing problems/diagnoses established on 1/4/11. At Risk Assessments were completed on 3/24/11 and revealed Individual #134 was: at high risk for: Respiratory Compromise, Cardiac Disease, and Fluid Imbalance and medium risk for: Choking, Aspiration, Circulatory, Gastrointestinal Problems, Osteoporosis, Infections, Polypharmacy (related to cardiac medications), and Falls. The nursing problems/nursing diagnoses and Health Maintenance Plans listed above were consistent with risk factors identified.	

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		Section XI Nursing Summary included a list of past surgical histories going back to 2000, Sick Call visits and their purpose, and diagnostic testing. The summaries were written based on the Health Maintenance Plans, with an attempt to summarize each nursing problem/nursing diagnose. Although the summary sections in Section I through IX were well summarized it did not assist the Nurse Case Manager in analyzing and summarizing the nursing problems/nursing diagnoses. The summaries failed to compare the health status of each problem to previous quarters, to indicate whether Individual #134's health status was progressing, maintaining or regressing toward established goals and objectives. The effectiveness of the Health Maintenance Plans was not addressed. The nursing summary primarily consisted of listing health problems, diagnostics testing, and treatment regimen. The Monitoring Team's review of the remaining 16 individuals' Quarterly and Annual Comprehensive Nursing assessment revealed the same trends as were listed for the above individuals. The lack of the Nurse Case Managers' adequately summarizing the clinical data into a meaningful summary reflecting individuals' progress or lack of progress regarding their health status does not appear to be due to lack of willingness or motivation. Rather, it appears to be due to the lack of adequate training in completing the summaries. The issues identified above were discussed in meetings with the Nursing Operations Officers, Nurse Managers, and Nurse Case Managers. Although the State was in the process of providing physical assessment training for RNs statewide, it may take a long time to complete the training for all RNs, perhaps as long as two years. In the meantime, it is imperative that Facility Nurse Case Managers receive additional training on completing the Comprehensive Nursing Assessment now. The Nursing Department needs to develop and implement a clinically sound competency-based training curriculum for Comprehensive Nursing Assessments and ensure that the Nurse Case Managers are appropriately trained. The Facility's Plan of Improvement stated they were not incompliance with provision and the Monitoring Teams concurs with their findings.	
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	Since the last compliance review the State and Facility had developed the At Risk Individuals Policy and Procedure and Risk Guidelines as well as the Aspiration Pneumonia Evaluation Procedures. According to the Facility's Plan of Improvement, At Risk training was initiated on 12/20/10 with Webinars from the State Office. In January 2011 the Facility provided competency-based training on individual homes regarding the risk process and aspiration pneumonia. On 1/2011 the Nurse Case Managers trained the direct care professionals on the Aspiration Trigger Data Sheet. On 2/1/11 the Aspiration	Noncompliance

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	high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Trigger Data Sheets were implemented by the nursing and direct care professional staff. The nursing staff monitored the data sheets daily. Since the last compliance review the Nursing Department had continued to use the Health Care Protocols for Developmental Disability Nurses to assist with care planning. According to the Facility's Plan of Improvement the Nursing Department had provided the Nurse Case Managers with training on 12/9/10 and 1/6/11 on Health Maintenance Plans and Acute Care Plans required for all individuals with high and medium risk factors and chronic health conditions. It was positive to find that the Nursing Department had ceased the practice of only training the Home Supervisors and/or Residential Coordinators and relying on them to provide training on the plans to the direct care professionals as was identified in previous compliance reviews. The Monitoring Team's review of 20 individuals' Health Maintenance Plans and Acute Care Plans showed some improvements. The Health Maintenance Plans for 20 individuals, who were identified as being at high and/or medium risk for specific health risk indicators and/or chronic conditions included Individuals: #479, #481, #6, #797, #573, #442, #223, #264, #375, #348, #134, #740, #415, #632, #385, #149, #363, #498, #235, and #267. The Monitoring Team reviewed 69 Health Maintenance Plans and 24 Acute Care Plans for a total of 93 plans. Since the last compliance review it was apparent that the nursing staff were striving to meet compliance with their development and implementation of the care plans. While some improvements were found, the need for continued improvement in individualizing the care plans to meet individuals' identified risk factors and chronic conditions remained. The findings are listed below. This data will serve as a benchmark for future compliance reviews: • The plans were beginning to show more individualization. However, often only the individuals' names were inserted into the Health Care Protocols for Development Disability Nursing template. Others also contained some Physician's Orders for specific medications and treatments, with a few specific nursing interventions. • Most of the plans were copied directly from the stock Health Care Protocols for Development Disability Nursing templates and continued to contained information, interventions, and training issues for the direct care professionals that were not applicable to the individuals' risk factors and/or chronic conditions. • The plans failed to specify who would implement the interventions, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. • Often multiple risk factors and/or chronic conditions were grouped together	

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		into one plan. • Several plans were continued on the out dated care plan format and had not been revised since the implementation of Health Care Protocols for Development Disability Nursing template. • The plans often failed to contain documentation that the Nurse Case Managers had reviewed and/or revised the plan at the Quarterly and/or Annual Comprehensive Nursing Assessments or when the individuals' health status changed. • None of the plans demonstrated collaboration with other disciplines. Further analysis of the 93 combined Health Maintenance Plans and Acute Care Plans revealed the following: • Of the 93 combined plans reviewed, 28 (30%) did not contain appropriately individualized baseline data. • Of the 93 combined plans reviewed, 34 (37%) did not contain appropriately individualized goals. • Of the 93 combined plans reviewed, 34 (37%) did not contain adequately individualize nursing interventions. • Of the 93 combined plans reviewed, 30 (32%) did not contain adequately individualized training for the direct care professionals. • Of the 93 combined plans reviewed, 27 (29%) did not contain documentation on the plans or attached training sheets validating that the direct care professionals had received training on the plans. • Of the 69 Health Maintenance Plans reviewed, 41 (59%) failed to contain verification that the plans were reviewed/revised quarterly and/or annually. • Of the 24 Acute Care Plans that should have been resolved, 10 (42%) failed to contain a resolution date. Examples of findings included: • Individual #267 had Health Maintenance Plans that did not document that they were reviewed/revised at the time of Quarterly and/or Annual Comprehensive Nursing Assessments: o Weight, Under, dated 11/10/10. o Psychotropic Medication for Side Effects, dated 9/20/10. • Individual #149 had Health Maintenance Plans that did not document that they were reviewed/revised at the time of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans were dated 1/5/11 for: Potential for Injury/Skin integrity, GERD, and Psychotropic Medication for Side Effects. • Individual #385 had Health Maintenance Plans written on the outdated care plan template and did not document if they were reviewed/revised at the time	

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		of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans dated 5/14/10 for: Seizure Disorder, Dyslipidemia, Risk for impaired Skin Integrity, Hypothyroidism, Osteoporosis, and Enteral Feeding, GERD, Hiatal Hernia, and Reoccurring Health Care Associated Pneumonia. • Individual #632 had Health Maintenance Plans written on the outdated care plan template not documented were not reviewed/revised at the time of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans dated 6/16/10 for: Nutrition and Weight, Constipation, Osteoporosis, Seizure Disorder, Gastroesophageal (GERD), Enteral Feedings, Aspiration Pneumonia, and Chronic Aspiration Syndrome. • Individual #740's Health Maintenance Plans were not reviewed/revised at the time of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans dated 1/4/11 for: Nutrition and Weight, Diabetes Mellitus (type not specified), Congestive Heart Failure (CHF) and Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Allergies, Pulmonary Restrictive Disease, Allergic Rhinitis, GERD, and Pneumonia. • Individual #740 had Health Maintenance Plans written on the outdated care plan template and did not document if they were reviewed/revised at the time of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans dated 6/2/10 for: Hypothyroidism, and 6/28/10 for: GERD, Psychotropic Medication for Side Effects, Weight, Over, and Hypertension. • Individual #348 had Health Maintenance Plans were not reviewed/revised at the time of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans dated 6/2/10 for: Seizure Disorder and Risk for Impaired Skin Integrity. • Individual #223 had Health Maintenance Plans written on the out dated care plan template and did not document if they were reviewed/revised at the time of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans dated 6/8/10 for: GERD and Osteoporosis. • Individual #573's Health Maintenance Plans were not reviewed/revised at the time of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans dated 12/29/10 for: Decubitus Ulcer and Urinary Tract Infection, and dated 1/10/11 for GERD and Enteral Feeding. • Individual #797's Health Maintenance Plans were not reviewed/revised at the time of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans dated 12/3/10 for: Hypertension, Constipation, Onychomycosis, Blindness, and Osteopenia, and dated 12/20/10 for: Renal Calculi. • Individual #481's Health Maintenance Plans were not reviewed/revised at the time of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans dated 2/18/10, and dated 8/14/10 for: GERD and Seizure Disorder. • Individual #479's Health Maintenance Plans were not reviewed/revised at the	

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		time of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans dated 9/16/10 for: Constipation and Falls - Potential for Injury. • Individual #6's Health Maintenance Plans were not reviewed/revised at the time of Quarterly and/or Annual Comprehensive Nursing Assessments: Plans dated 1/11/11 for: Tracheostomy Care. Individual # 6 had Acute Care Plans for Bacterial Upper Respiratory Infection on 9/10/10 and Pneumonia on 1/13/11. Individual #6 had medium risk levels for Aspiration and Respiratory. However, Individual #6 failed to have Health Maintenance Plans for Aspiration and Respiratory risk factors. • Some of the Health Maintenance Plans had risk factors and/or chronic conditions combined on the plans, e.g., Individual #385 had a combined plan for Enteral Feeding, GERD, Hiatal Hernia, and Reoccurring Health Care Associated Pneumonia. Individual #632 had a combined plan for GERD, Enteral Feedings, Aspiration Pneumonia, and Chronic Aspiration Syndrome. Individual #740 had combined plans for Congestive Heart Failure (CHF) and Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Allergies, Pulmonary Restrictive Disease, Allergic Rhinitis, GERD, and Pneumonia. Individual #573 had a combined plan for GERD and Enteral Feeding. The Health Maintenance Plans and Acute Care Plans need to be more than a perfunctory paper exercise. The purpose of the plansis to identify specific interventions for each identified significant risk factor and nursing problem/diagnosis and to improve, to alleviate, or maintain individuals' health status. All plans must be individualized. They must be reviewed at least at the time of the Quarterly and/or Annual Comprehensive Nursing Assessment, or when individuals' health status changes related to the identified risk factors or chronic conditions. For the plans to be meaningful and beneficial the Nurse Case Managers need to carefully review all clinical data and collaborate with other relevant disciplines to achieve integrated plans of care, as required in Sections G and F of the Settlement Agreement. The Health Care Protocols for Developmental Disability Nurses and plan templates should only be usedas a reference guide. These issues were discussed at a meeting with the Nursing Operation Officers, Nurse Managers, and Nurse Case Managers Supervisor. The Nursing Department needs to develop and implement a clinically sound competency-based training curriculum for Health Care Plans and ensure: • Health Maintenance Plans and Acute Care Plans are individualized beyond the baseline data and goals. • Information and/or interventions contained on the Health Care Protocols for Developmental Disability Nurses and plan templates that are not applicable to the individuals' risk factors and/or chronic conditions need to be deleted. • The plans specify who would implement the interventions, how often they were to be implemented, where they were to be documented, how often they would	

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		be reviewed, and/or when they should be considered for modification. • Risk Factors and/or chronic conditions are not combined into one plan because each problem may require different interventions, monitoring, and direct care professional training issues. • Health Maintenance Plans and Acute Care Plans are developed collaboratively with other relevant disciplines. • The current operating Health Maintenance Plans and Acute Care Plans are maintained in the individuals' official medical record. • When Health Maintenance Plans and Acute Care Plans are established the documentation should be written on the Health Maintenance Plans, the Acute Care Plans, and in the Integrated Progress Notes validating that direct care professionals were trained and the plans were implemented. • When the Quarterly and/or Annual Comprehensive Nursing Assessment are completed or when individuals' health status related to the identified risk factor or chronic condition health status changes the Nurse Care Managers must review and revise, as indicated, the Health Maintenance Plans and Acute Care Plans, and document that it was done on the plans. • Plans written on the template previous to the initiation of the Health Care Protocols for Developmental Disability Nurses and plan template need to be revised on the new template. • When plans are resolved, document that they are, and file separately from the active plans. The Facility's Plan of Improvement stated they were not in compliance with provision and the Monitoring Teams concurs with their findings.	
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.	Since the last compliance review the following new policies were implemented: • RSSLC Behavior Intervention, Use of Restraint, J.1, Revised: 3/1/11 • RSSLC Behavior Intervention, Completing the Restraint Checklist/Monitoring Restraint Use, J.02, Revised: 3/1/11 • Texas Department of Aging and Disability Services, State Supported Living Centers, Nursing Protocol: Pre-treatment and Post-sedation Monitoring, Date: 2/2011 • RSSLC Policy: Nursing Services, I.00b, Effective: 4/1/11 • Texas Department of Aging and Disability Services, State Supported Living Centers, Procedure: Medication Administration Guidelines, Date: 2/2011 • RSSLC Pharmacy Policy and Procedure Manual, Medication Errors/Variances, 01.05.20, Date: None • RSSLC Nursing Procedure Manual, Hiring of Nursing Personnel, A.00, Dated: 2/24/11 • RSSLC Nursing Procedure Manual, Administration of Oral Medications, Revised:	Noncompliance

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		2/24/11 • Texas Department of Aging and Disability Services, State Supported Living Centers, At Risk Individuals Policy/Aspiration Pneumonia Initiative: Frequently Asked Questions, Date 12/20/10 • RSSLC On-Call Medical Guidelines, Date: 4/8/11 The Monitoring Team requested the status of all required nursing training that had occurred over the last six months. What was supplied in the document request was a three-inch stack of training material. The material included the Index of Monthly Training/In-services, completed In-service Sign-in sheets that listed the topic trained, and the accompanying training materials. To determine the status of training on a topic would require going through each of the sign-in sheets, separating by topic, and comparing the names listed against the names of all nurses. To do this for each required topic, or whenever there was a need to ensure which nurses have been trained or need to be scheduled, would be an inefficient use of staff time. The Nurse Educators were requested to provide a list describing each topic trained and the percentage of nurses trained on each required topic as well as a projected completion date for nurses delinquent in the required training. The Monitoring Team was informed that the Nursing Education Department did not maintain a centralized database to track training. The Nurse Educators stated that although they did not have a formal tracking tool for all the in-services/training completed, they had a training index and signature sheets indicating what the training was on and who was trained. The signature sheets were designed so that each unit had their own sheet and by doing so one can easily track the percentage trained and who needs training. The Nurse Educator reported there was a campus-wide training on the policies with 95% of the nurses trained, with a projected date for completion by July 30, 2011. The Monitoring Team did not have confidence in this percentage of training completed due to the lack of a quantitative tracking system. More importantly, it is a hindrance to the Facility's ability to track and ensure training. The Monitoring Team explained to the Nursing Operations Officer and Nurse Educators that it should be the responsibility of the Nursing Department's Nurse Educators to track all required training completed, to ensure that training was provided timely, and to be sure training for each nurse is kept up to date. The Nursing Operations Officer and Nurse Educators assured the Monitoring Team that a centralized training database would be developed and implemented by the next compliance visit. The Nursing Department needs to ensure that a centralized database is developed and implemented to track all required nursing training; it should include a running percentage of nurses trained monthly and a list of nurses trained, with a projected completion date for nurses delinquent in the required training.	

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		The Monitoring Team's review of the training material content found many of the polices/procedures, forms, and other training materials were out of date. It is the responsibility of the Nurse Educators to consistently ensure that that all training materials used to train nursing staff are current, sound in practice applications, competency-based; and training is provided timely, and tracked. The Nurse Educators failed to have formal lesson plans for each of the training topics. Rather, copies of the policies and procedures or other material were provided as documentation of the training provided. It was rare to find training topics that contained competency-based testing. The competency-based testing material reviewed were generally weak in content and inadequate to provide the depth of knowledge and clinical skills necessary to equip the nursing staff to perform completely. Typically, nurses perform proportionately to how well they are trained and mentored through the learning process. In order for the Nurse Educators to be effective they must be experts in all aspects of developmental disability nursing required at the Facility. The Nurse Educators need to develop formalized lesson plans with competency-based testing for all training provided. The lesson plan should include, but not be limited to, the following elements: • Before developing the lesson plan the instructor should thoroughly review the content of the topic to be taught and identify the essential content that will achieve the maximum effectiveness. • Establish timelines for topic taught. • Identify necessary training materials and equipment. • State the lesson objectives for learning and skill acquisition. • Develop lecture/presentation content, with emphasis on the learning and skill acquisition objectives. • Develop strategies to enhance the learning process and keep the students interested. • Provide frequent positive feedback to motivate students to learn. • Foster the development of critical thinking skills. Ask Why, How, If, and What Else questions to strengthen student comprehension of the content and skills. • Develop competency-based tests, including a test bank of questions that can be used interchangeably from lesson to lesson. Develop a key for each of the test bank questions for easy of scoring. Test out the questions before use to ensure that questions are sound, stated clearly for the student to understand, and measure the established objectives. If the training requires skill acquisition, arrange for return demonstration. The return demonstration should be part of the competency-based testing and weighted as part of the test. Set an absolute score for demonstrating competency. • After the training session allow the students an opportunity to evaluate the effectiveness of the training. The evaluation process is invaluable in helping the	

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		instructor strengthen the lesson content and improve teaching style. The State was in the process of implementingan enhanced competency-based training curriculum on physical assessment, care planning and critical thinking skills for RNs. The Facility Nurse Educators will receive training by the nurse practitioners. The training consists of didactic instruction as well as "hands on" clinical practicum. The Facility Nurse Educators will provide the training and competency-based testing for the Facility RNs with oversight provided by the Nurse Practitioner Consultant. All RNs will be expected to take the physical assessment training including the nursing administrative staff. In addition to the training, the State planned to supply all the RNs with the Mosby/Elsevier Nursing Diagnosis Handbook, Eight Edition, as an adjunct to the competency-based training. The package of materials included textbooks, lab manuals, and online resources. The Monitoring Team agreed that the Facility RNs need enhanced training on physical assessment based on previous and current compliance reviews. The RNs need enhanced training in the areas of physical assessment, critical think skills, analysis for clinical data; and the ability to adequately analyze and summarize clinical data derived from Quarterly and Annual Comprehensive Nursing Assessments. Competency in achieving these nursing skills is vital in determining individuals' heath status by comparing progress quarter to quarter and annually toward the achievement of established goals and objectives. After RNs receive the enhanced physical assessment training it will be important for the Monitoring Team to evaluate for improvement in the quality of the nursing assessments and care plans. Individuals residing in developmental centers have numerous co-morbid conditions and many are aging; therefore, it is imperative that the RNs be able to exercise critical thinking skills in taking their assessment findings and applying them to developing, implementing, and evaluating plans of care that are individualized and have realistic goals andobjectives that meet that individuals'unique needs for care.It will take considerable time on the part of the State and Facilities to complete the training for all RNs statewide. In the meantime, the Facility Nurse Educators need to continue to enhance competency-based training for the nursing staff as mentioned above. The State's Supportive Living Centers (SSLC) Nurse Educator Workgroup was in the process of finalizing the SSLC Nurse Educator Handbook, which will standardize training throughout the Facilities. This was a positive step forward in improving the quality and competency of the nursing education. The Facility's Plan of Improvement stated they were not in compliance with provision of the Settlement Agreement and the Monitoring Team concurs with their findings. Since the last compliance visits numerous policies and procedures had been added and the nursing staff trained. The Nurse Educators need to review and revise training materials	

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		to ensure they are current and develop formalized lesson plans with competency-based testing for all training provided. In addition, the Nurse Educators need to develop and implement a database to track all training.	
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.	With the implementation of the new At Risk Individual Policy, the Health Status Teams no longer exist. The new policy indicated that nursing along with the physician/nurse practitioners were responsible for assessing risk factors for the following categories: • Aspiration • Respiratory Compromise • Cardiac Disease • Constipation/Bowel Obstruction • Diabetes • Gastrointestinal Problems • Seizures • Skin Integrity • Infections • Fractures • Fluid Imbalance • Hypothermia • Urinary Tract Infections • Circulatory Since the last compliance review the State and Facility had developed the At Risk Individuals Policy and Procedure and Risk Guidelines. According to the Facility's Plan of Improvement At Risk training was initiated with Webinars from the State Office. In 1/2011 the Facility provided competency-based training on individual homes regarding the risk process and aspiration pneumonia. In 1/2011 the Nurse Case Managers trained the direct care professionals on the Aspiration Trigger Data Sheet. On 2/1/11 the Aspiration Trigger Data Sheets were implemented by the nursing and direct care professional staff. The nursing staff monitored the data sheets daily. The Monitoring Team attended three PSP/ At Risk meetings for Individuals #442, #385, and #363. The new At Risk process demonstrated improvement over the previous Health Status Team review process. It allowed for more time for team members to review and discuss risk factors for each individual reviewed. It also allowed the opportunity for all team members who knew the individuals best to participate. However, the facilitators read each the individuals' established risk scores and did not assertively elicit information from the team members. Much like the previous risk process the discussion of assessments followed the criteria on tool with very little	Noncompliance

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		deviation. The facilitators need to elicit more discussion and all relevant clinical data should be explored in order to adequately and accurately determine individuals' level of risk for the relevant risk factors. The Facility's Plan of Improvement indicated they were not in compliance with the provision of the Settlement Agreement, which was consistent with the Monitoring Team's findings.	
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.	According to the Nursing Department, various medication administration functions continued to be monitored. Listed below are the items monitored: • Each Nurse Case Manager observes two medication passes per month (one per shift per caseload). Sample size audited is two per month per unit. • In the Infirmary the Charge Nurse for each shift completes a medication pass observation on each nurse on their weekend rotation. Sample size audited is one per week. • Medication Administration Record audits of the signature sheet are completed every shift by the nurse (RN or LVN). Sample size audited is one per month per unit. • A second signature on the monthly Medical Administration Record Checklist is completed monthly by the nurse (RN or LVN). Sample size audited is one per month per unit. • The second signature on Physician's Orders is completed by the nurse (RN/LVN) as orders are transcribed. Sample size audited is once per month per unit. • The second signatures on Quarterly Orders are completed by the nurse (RN/LVN) quarterly. Sample size audited is one per month per unit. • Each Nurse Manager randomly inspects the Medication Room one a month. Sample size audited is one per month per unit, as applicable. • The Empty Medication Vials Pharmacy Shortage/Coverage Forms (if any injectable medications were used, this form is completed and the empty vial sent to the Pharmacy). These forms are completed by the nurse (RN/LVN). Sample size audited is one per month per unit, as applicable. In addition to the Nursing Department's monitoring functions completed on medication administration practices, the Quality Assurance Nurses also completed monitoring on various medication administration practices. They included: • All Medication Rooms – twice a year o All medication rooms on campus were inspected at least twice a year accompanied by the unit nurse. o The rooms were checked for: security; that medications were stored properly, e.g., if internal and external medications were separated, food items in the refrigerator were labeled with the date opened; medication separated from food items; no personal food or drinks present; and	Noncompliance

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		refrigerator temperatures monitored. • Positioning of individuals – periodically o Individuals were checked for proper positioning periodically to ensure that those with G/J tubes or Gastroesophageal Reflux Disease (GERD) were positioned properly. o Positioning was also checked during medication administration observations. o If an individual was positioned poorly the direct care professional was immediately asked to reposition the individual • Medication Administration Records – quarterly o Current Medication Administration Records (MARs) were checked quarterly to ensure all medication errors were identified. o If medication errors were found the medication nurse accompanying the Quality Assurance Nurses was advised as well as the Unit Nurse Manager. o The Narcotic Logs were checked for two signatures at each shift change. • Medication Administration Observations were performed using the standardized form – the frequency of the observations and sample size was not made available for review. While there were no trend analysis data available for the above items monitored there was documented evidence that the Quality Assurance Nurses took corrective action when deficiencies were identified and written reports were sent to the Chief Nurse Executive and/or other relevant disciplines. From this description in the above bullet of the frequency in which Medication Administration Observations were completed it could not be discerned if this indicated whether each nurse administering medications were observed quarterly. The Monitoring Team was provided with a stack of at least 277 completed Medication Observation forms completed, 10/2010 through 3/2011. Neither was there a monthly Medication Administration Observation schedule available to review validating that the medication nurses were scheduled and completed the required medication administration observations. There was no formal report analyzing and summarizing the result for the Medication Administration Observation data. Without data provided routinely in a report, there is no way to trend the information to determine whether errors in medication administration were increasing or decreasing, or the types of errors that are occurring. Furthermore, there would be no convenient way to verify that all nurses administering medications were monitored on a quarterly basis. The Nursing Department needs to review and analyze the data from the Medication Observations to	

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		identify problematic trends from which corrective action plans can be generated. The Nursing Department needs to develop a system to aggregate these data so it becomes usable to facilitate the identification of trends, analysis of data, and development, when indicated, corrective action plans. The Monitoring Team's review of 277 completed Medication Administration Observation forms found that the vast majority of them identified no problems, which did not comport with the Monitoring Team's observations during medication administration in the Infirmary. Of the 277 competed Medication Administration Observation Forms reviewed, six (2.2%) had the following problems identified. They included: • Failure to use proper hand washing, with soap and water or to use hand sanitizers during medication administration. • Failure to clean the pill crusher before and after use. • Failure to follow the correct diet texture/crush medications. • Failure to write the date, time and signature when medication containers were opened. • Failure to remove the keys from the medication cart in the medication room. • Failure to sign the Narcotic Log Since the Quality Assurance Nurses also conduct Medication Administration Observations, the Facility needs to initiate inter-rater reliably check for these observations. The Monitoring Team's review of the Medication Administration Observation form, Revised 2/2010, found it failed to include a question regarding the nurses' review of the PNMP. The form contained one question regarding fluid consistency, e.g., #24, "Did the person require thickened liquids for medication administration." It failed to include other questions regarding alternative dining instructions, e.g., food texture, use of adaptive equipment, positioning and special food presentation techniques. The Medication Administration Observation form needs revision to include an additional question for all alternative dining instructions.. The Monitoring Team was provided with multiple completed sheets for daily Medication Administration Record audits for signatures and monthly Medication Room audits. The data for the other audits completed for: the second signature on the monthly Medical Administration Record Checklist, the second signature on Physician's Orders, the second signatures on Quarterly Orders, and Empty Medication Vials Pharmacy Shortage/Coverage Forms, was not available for review. The Nursing Department needs to develop a system to aggregate these data, as with the Medication Administration Observation data, so the data can be used to facilitate the identification of trends,	

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		analysis of data, and development, when indicated, corrective action plans. The Monitoring Team conducted Medication Administration Observations in the Infirmary on 5/4/11 and 5/5/11, accompanied by the Quality Assurance Nurses. The following significant issues were identified during the observations, most of which had the potential to place individuals involved at risk: • After inspecting the stoma site and checking for placement, the nurse left the medication cart unattended, with the medications for administration on top of the cart, to go out of the room to wash hands because there was no sink for hand washing in the room. • Without prompting the nurses did not consistently explain the medication and their purpose to individuals. These individuals did not have Self Administration Programs; however, the nurses failed to provide informal training. • The nurses did not reposition to achieve correct body alignment without prompting. • The nurses did not refer to individuals' PNMP. Neither were PNMPs included in the Medication Administration Records. Apparently the PNMPs were not sent over from the units when individuals were admitted to the Infirmary. • Individual #286 had the PNMP taped to the wall at the head of the bed and another sign was posted on the wall with Individual #286's name and instructions for the use of elbows and hand splints. The splints ordered for Individual #286's elbows and hands were not in place and could not be located at the time of the observation. Posting personal information on the wall for all to see was a violation of privacy. The Monitoring Team pointed this out to the staff but the information posted on the wall above Individual #286's bed was not immediately removed. Individual #286 was also wearing an identification bracelet, apparently left on after returning from the hospital admission. This was another violation of privacy. Additionally, Individual #286's personal care items and other items were observed lying on the floor left side of bed. The nurse explained that the room individual #286 was occupying had not been used until recently and was not fully furnished. However, individual #286 had been admitted to the Infirmary for at least five days, ample time for the staff to have secured furnishing for personal items. This was a violation of environmental cleanliness and safety as well as demonstrating the staff's lack of respect for Individual #286's personal property. • One nurse, after checking the medication for administration to Individual #551 against the Medication Administration Record in the medication room, then removed the pill from the package and put it in a pill cup and placed it on the medication cart. The opened package was left on the medication room counter. The medication cart was then taken to the room for administration. Medication	

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		must be identifiable up to the point of administration. This was a serious violation of safe medication administration practices. The Monitoring Team informed the nurse of this violation. On the way out of the medication room the nurse neglected to place hand sanitizer on the medication cart. The Monitoring Team handed the nurse a bottle of hand sanitizer to use during medication administration because of the lack of a sink for hand washing in the individual's room. While the Monitoring Team observed the nurse administer medications via G-tube, Individual #551 was noted to have dry crusty, peeling and cracked lips with mucous around the mouth. In addition to the dry lip it did not appear that Individual #551 had received recent oral hygiene. This was pointed out the medication nurse and the Quality Assurance Nurses who prompted the nurse to provide oral care and moisture to the lips. • During the Medication Administration Observations on 5/4/11 the Quality Assurance Nurse pointed out that Individual #375's Quarterly Orders had expired. It was not until the Monitoring Team was reviewing documents shipped for off-site review that it was fully realized that the failure to have Quarterly Orders went back to 1/10/11. At the time of the review the Monitoring Team assumed the Quarterly Orders had not been updated since Individual #375's admission to the Infirmary on 5/1/11 post hospital discharge. The Monitoring Team reviewed e-mail communication of 5/4/11 at 1:42 p.m., from the Quality Assurance Nurse to the Chief Nurse Executive, Nursing Operations Officer, Administration, Infirmary Nursing Director, Infirmary Supervisor, with copies to the Assistant Program Director and Quality Assurance Director informing them of the lapse of Individual #375's Quarterly Orders since 1/10/11. Yet, by approximately 5:45 p.m. on 5/5/11, when the Quality Assurance Nurse checked the Quarterly Orders for Individual #375, they had not been updated. The Quality Assurance Nurse called this to the attention of the Infirmary Nursing Director, who explained that she had told the nursing staff on 5/4/11 to contact the unit and update the Quarterly Orders. There was documented evidence that the Infirmary Director sent e-mail communication at 6:39 p.m. on 5/4/11 to all relevant Infirmary nursing staff and the Infirmary Supervisor. The e-mail stated, "When the individual is admitted to the Infirmary get the Quarterly Orders and have the MD review on the day of admission. Effective today, 5/4/11." Since the Individual #375's Quarterly Orders still had not been updated, it was suggested the Infirmary Director immediately take corrective action. It should have been the responsibility of the Infirmary nurse admitting Individual #375 to the Infirmary from the emergency room to check all Physician's Orders and ensure that Quarterly Orders were current. According to another e-mail communication on 5/4/11 at 2:36 p.m., the Quality	

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		Assurance Nurse responded to an e-mail from the Assistant Program Director, written on 5/4/11 at 1:59 p.m., which asked about the Infirmary's lack of current Quarterly Orders and for the names and homes of the individuals' who were lacking orders. The Quality Assurance Nurse provided Assistant Program Director with their names and homes. The Quality Assurance Nurse stated that Individual #564 was identified the previous Friday (4/29/11) as not having up dated Quarterly Orders. However; Individual #564's nurse notified the Pharmacy when told about the lack of updated Quarterly Orders. Individual #402 was identified on 5/4/11 as not having current Quarterly Orders. The Quality Assurance Nurse recommended that a process be put in place [presumably, for ensuring that Quarterly Orders were obtained]. Although the Infirmary Director did send an e-mail to the Infirmary nursing staff stating, "When the individual is admitted to the Infirmary get the Quarterly Orders and have the MD review on the day of admission. Effective today, 5/4/11" it was apparent that the Infirmary did not have a formalized process for ensuring that Quarterly Orders were obtained from the units when individuals were admitted to the Infirmary. This did not represent a formalized process to ensure that the problem was resolved. If nurses administered medications without current orders, it amounted to medication errors and a violation of the Nurse Practice Act. If that was the situation, then, Medication Error Reports should be completed for each medication administered on expired orders and corrective action taken with the nurses responsible for the lack of current Quarterly Orders. Based on the problematic issues identified during the Monitoring Team's observations and review of documentation, the Infirmary Nursing Director and Infirmary Supervisor need to be more proactive in routinely conducting over the shoulder supervision of the nursing staff, review admission and ongoing documentation as well as making rounds on each shift to observe individuals' nursing care, and to conduct environmental surveillance. In addition, the Infirmary Director needs to put in place a formal system for ensuring that Quarterly Orders are obtained and current when individuals are admitted to the Infirmary. The Monitoring Team reviewed 10 of the last Medication Error Reports submitted through the document request.The following issues were identified. This data will serve as a benchmark for future compliance reviews: • Of the last 10 medication errors submitted through document request, seven were committed by the nursing staff and three were committed by the pharmacy staff. • One of six (17%) medication errors committed by the nursing staff contained	

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		notification of physician. • Six of the 10 (60%) medication errors discovered by the nursing staff contained the date the error was discovered. Four of the 10 (40%) errors discovered by pharmacy staff failed to date the time the errors were discovered. • None of three (0%) medication errors (dispensing) committed by the pharmacy staff contained notification of the physician. They were Category A: Circumstances or events that have the potential to cause error. • In six of the seven (86%) medication errors committed by the nursing staff, the Nurse Managers had followed-up with review and counsel to the nurse the day the error was discovered. This was a significant improvement since last the last compliance review. Four of the 10 (40%) medication errors discovered by the pharmacy, including one committed by the nursing staff, failed to have follow-up by the supervisor and counsel. • Four of the 10 (40%) medication errors discovered by the pharmacy staff failed to mark any of the Possible Cause of Error Section. • Six of the 10 (60%) medication errors discovered by the nursing staff only marked few of the Possible Cause of Errors. If the medication error system is to be able to analyzed possible causes for medication errors as a means of identifying information useful to prevent factors contributing to medication errors, it is vital that all Possible Causes for Error are filled out completely. • In summary, one of 10 (10%) Medication Error Reports contained notification of physician. According to RSSLC's Medication Errors Policy, 01.05.20, #2, "When a medication error is detected, 'Medication Error Data Entry' form shall be filled out at once by the individual who has detected the error." The policy for medication variances is not specific with regards to physician involvement. Physicians must play an active role in assessing and monitoring the individual. Refer to Provision N.8 for additional information. Since the last compliance review it was positive to find in the review of20 individuals'Medication Administration Records for the last three months there were no blanks for medications administered. If medications were not given, the blocks were initialed and circled. This was a significant improvement from findings in previous compliance reviews where numerous blanks were found on the Medication Administration Records. This improvement was probably due to the increased efforts of the nursing staff to closely monitor the Medication Administration Records. Refer to M.1 for Documentation Audit information. It was positive to find since the last compliance review that the Pharmacy had developed and implemented a Medication Errors/Variances Policy that included errors/variances resulting from dispensing, distribution, erroneous data entry on profiles, missed	

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		allergies, administration, prescribing, order communication, storage, product labeling, packing, nomenclature, compounding, education, and monitoring. The policy also included the establishment of a Medication Variance Committee, chaired by the Pharmacy Director, which meets monthly to review trends in medication variances and take corrective action. The core Committee membership included: Pharmacy Director, Medical Director, Psychiatrist, Dental Director, Chief Nurse Executive, and Quality Assurance Nurse. The Committee began meeting in January, 2011. As a result of the change in policy, the database for tracking all medication errors/variances had been revised and was still undergoing refinement. Review of the Medication Variance Committee, 1/20/11, 2/17/11, 3/17/11, and 4/12/11 revealed significant improvement in reporting all types and numbers of medication errors/variances, along with reports of corrective actions taken with the respective discipline committing the medication errors/variances. A description of the monthly medication errors/variances and corrective actions taken are listed below. This data will serve as a benchmark for future compliance reviews. • For the fourth quarter, the 1/25/11 Pharmacy and Therapeutics Committee reported a combined total of 33 medication errors. The error variances were not broken down by discipline or described. Medication errors/variances reported through the Medication Variance Committee Meeting Minutes, 1/20/11, 2/17/11, 3/17/11, and 4/12/11 contained more substantive information. These data will serve as a benchmark for future compliance reviews. • December 2010: o Nursing reported three medication variances; all were dose omissions. o Pharmacy reported 28 variances, of which 27 were prescribing variances and one was a wrong drug dispensed from the After Hours Cart. The breakdown of prescribing variances were identified as: ▪ 21 – no allergies documented on the order page ▪ 1 – had no stop date written ▪ 1 – duplication of ordered medication ▪ 1 – no directions were written ▪ 3 – no diagnoses were written o Copies of the prescribing variances were forwarded to the Medical Director in order to inform and retrain the staff involved. o Nurses committing medication variances were retrained and were required to pass a medication observation, monitored by an RN, prior to resuming administering medication on their own. • January 2011: o Nursing reported two medication variances, for which one was an	

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		omission error and the other was a missing medication from stock medications. o Pharmacy reported 28 variances, for which 17 were prescribing variances and 11 were dispensing errors. o A total of 30 variances were reported o The breakdown of prescribing variances were identified as: ▪ 6 – No allergies documented on the order page ▪ 1 – No stop date was written ▪ 2 – No routes were written ▪ 7 – No diagnoses were written ▪ 1 - No signature was included o The pharmacy staff involved in dispensing variances were informed and retrained. o Copies of the prescribing variances were forwarded to the Medical Director in order to inform and retrain the staff involved. o Nurses committing medication variances were retrained and were required to pass a medication observation, monitored by an RN, prior to resuming administering medication on their own. • February 2011: o Nursing reported two medication variances, for which one was an omission variance and the other was treatment to the wrong side of the body. o Pharmacy reported 29 variances, for which 10 were prescribing variances and 19 were dispensing errors. o A total of 31 variances were reported o The breakdown of prescribing variances were identified as: ▪ 2 – No allergies documented on the order page ▪ 1 – No stop date was written ▪ 1 – No route was written ▪ 6 – No diagnoses were written o The pharmacy staff involved in dispensing variances were informed and retrained. o Copies of the prescribing variances were forwarded to the Medical Director in order to inform and retrain the staff involved. o Nurses committing medication variances were retrained and were required to pass a medication observation, monitored by an RN, prior to resuming administering medication on their own. March 2011: o Nursing reported 18 medication variances, for which seven were omission variances, nine were to wrong individual, one was a wrong	

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		administration technique, and one was an expired drug. o Pharmacy reported 25 medication variances, for which 15 were prescribing variances, nine were dispensing variances, and one was stocking an expired drug. o The breakdown of prescribing variances were identified as: ▪ 7 – Nurse, LVN ▪ 18 – Nurse, RN ▪ 1 – Pharmacist ▪ 9 – Pharmacy Technician ▪ 8 – Physicians ▪ 43 – Total o Of the 43 variances, 18 reached the individual and 25 were near misses o Mode for the variances were as follows: ▪ 0 – Procuring ▪ 1 – Stocking ▪ 16 – Prescribing ▪ 9 – Dispensing ▪ 17 Administering o The pharmacy staff involved in dispensing variances were informed and retrained. o Copies of the prescribing variances were forwarded to the Medical Director in order to inform and retrain the staff involved. o Nurses committing medication variances were retrained and were required to pass a medication observation, monitored by an RN, prior to resuming administering medication on their own. As demonstrated through review of the Medication Variance Committee Minutes and attendance at the 5/5/11 meeting, the medication variance system was progressively improving in identifying and describing medication variances, and in taking corrective action specific to the identified problems and disciplines committing the medication variances. The Clinical Pharmacist informed the Monitoring Team that the system was continuing to undergo refinements and improvements. In the future the system would include more specific information. Although the month of March 2011 reported an increase in the total number of medication variances that can probably be attributed to better reporting. The numbers of medication variances reported by the nursing staff were low in comparison to the other Facility disciplines and the other State Facilities of comparable size and composition. Considering the large population and the volume of medications administered daily, it is important that the Nursing Department ensure that nursing staff do not underreport medication variances. Refer to Provision N for more information.	

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		The Facility's Plan of Improvement stated they were not in compliance with this provision and the Monitoring Teams concurs with their finding. The most significant improvement was found with the development and implementation of the Medication Error/Variance Policy and formation of a Medication Error/Variance Committee. Although improvements were made with increased monitoring of medication administration practices and documentation since the last compliance review, the nurses in the Infirmary need to improve medication administrations practices. The Nursing Department needs aggregate Medication Administration Observation data into a system to track, analyze, and trend the data to identify systemic trends; and take corrective action on identified deficiencies. The Medication Error/Variance systems need to continue refinement in identifying all factors contributing to medication errors/variances.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. After the restructuring of the nursing staff, the Nursing Department should evaluate the ratio of nurses to individuals based on level of individuals' acuity in each Living Unit by shift to ensure adequate coverage of staff nurses.
2. Because of the lack of full-time nursing coverage on the 10-6 shifts in Leon, Neches, San Antonio, Three Rivers, and Four Rivers, it is imperative that the Nursing Department thoroughly train the direct care professional staff to recognize, respond to, and report basic signs and symptoms of changes individuals' health status to the nursing staff.
3. The Nursing Department needs to continually retain, recruit, and evaluate the need for additional staffing and other resources to meet the increasing needs of individuals served.
4. The Facility's Quality Assurance Department and Nursing Department must ensure that the monthly assigned monitoring tools are completed; and identify and reconcile the reason for the wide disparity between the monitoring results obtained by the Quality Assurance Nurses and the nursing staff.
5. The Nursing Department needs to ensure that nurses perform a complete nursing assessment on individuals for underlying changes in health status when individuals engage in atypical maladaptive behaviors as well as when there are any changes in health status. The nurses need to promptly notify the physicians and thoroughly describe the assessment findings. If the physicians do not promptly return phone calls the nurses must continue to contact the physicians, if unsuccessful the appropriate Facility authority should be contacted; unless the individuals' health status is determined to be an emergency, in which case the emergency response system must be initiated.
6. The Nursing Department needs to ensure that nurses receive training on assessing and managing the care of individuals with COPD and Restrictive Airway Disease.
7. The Facility should ensure that the Infection Control Program is adequately staffed with Infection Control Nurses and support staff to maintain a high quality and effective Infection Control Program.
8. The Infection Control Program needs to develop and implement a formal system for checking the reliability and timeliness of the infection data reported to ensure that all infections are reported; and to identify any infectious trends that may be emerging, and which require immediate attention.
9. The Infection Control Program needs to implement "real time" monitoring of acute infections to ensure that appropriate antibiotic therapy and precautions were being implemented and effective. Due to the potential for infectious diseases to spread, monitoring this area needs to be

conducted while the acute infections are active. Retrospective monitoring does not allow for immediate intervention and resolution of problematic issues.

10. The Infection Control Committee needs to develop and implement preventative plans related to the probable cause of infections identified through Infection Control Trend Reports to prevent or minimize their occurrences.
11. The Nursing Department should provide the Infection Control Nurse with the assistance of an Infection Control expert or formalized training in Infection Prevention and Control for Long-Term Care Facilities.
12. The Facility needs to ensure that all employees follow the Tuberculosis Skin Test Policy.
13. In order for the data derived from the Handwashing/Glove Use Form and Infection Control Form, to be useful, the Infection Control Nurse must aggregate analyze, and trend and develop corrective action plans developed for deficiencies.
14. The Wound Care Nurse needs to develop and implement a trend analysis to identify systemic skin integrity problems so that corrective action plans can be established and implemented to prevent or minimize skin integrity issues.
15. The Nursing Department needs to develop and implement a clinically sound competency-based training curriculum for Comprehensive Nursing Assessments and ensure that the Nurse Case Managers are appropriately trained.
16. The Nursing Department needs to develop and implement a clinically sound competency-based training curriculum for Health Care Plans..
17. The Nurse Educators need to consistently ensure that that all training materials used to train nursing staff are current, sound in practice applications, competency-based; and training is provided timely, and tracked.
18. The Nursing Department needs to ensure that a process is developed and implemented to track all required nursing training, to include a running percentage of nurses trained monthly with a projected completion date for nurses delinquent in the required training.
19. The Nurse Educators needs to develop formalized lesson plans with competency-based testing for all training provided.
20. The Nursing Department needs to review and analyze the data from the Medication Observations to identify systemic trends from which corrective action plans can be generated.
21. The Nursing Department needs to ensure that all Medication Administration Observation data derived from the use of the Medication Administration Observation form and/or statewide monitoring tools for medication administration observations are analyzed and trended, with plans of corrective action for identified deficiencies.
22. Since the Quality Assurance Nurses also conduct Medication Administration Observations, the Facility needs to initiate inter-rater reliably checks for these observations.
23. The Medication Administration Observation form needs revision to include an additional question for all alternative dining instructions, e.g., food texture, use of adaptive equipment, positioning and special food presentation techniques.
24. The Nursing Department, Infirmary Nursing Director and Infirmary Supervisor need to be more proactive in routinely conducting over the shoulder supervision of the nursing staff, review admission and ongoing documentation as well as making rounds on each shift to observe individuals' nursing care, and to conduct environmental surveillance. In addition, the Infirmary Director needs to put in place a formal system for ensuring that Quarterly Orders are obtained and current when individuals are admitted to the Infirmary.
25. If the medication error system is to be able to analyze possible causes for medication errors as a means of identifying information useful to prevent factors contributing to medication errors, it is vital that all Possible Causes for Error Section be filled out completely.
26. It is important that the Nursing Department ensure that nursing staff do not underreport medication variances.

The following are offered as additional suggestions to the facility:

1. The Facility should ensure that walkways are kept clean and free of bird droppings. Staff cleaning the bird dropping should use standard precautions to avoid potential transmission of disease or the Facility should contact the local Department of Health's Environment Services for proper disposal.

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. RSSLC Plan of Improvement, dated 4/18/2011 2. RSSLC Policy "Physician Order Review By A Pharmacist"-- Pharmacy Policy and Procedure Manual, undated 3. RSSLC Policy, Concurrent Drug Regimen Reviews, Pharmacy Policy and Procedure Manual, undated 4. Single Patient Intervention Reports and associated progress notes for Individuals #70, #570, and #526 5. Quarterly Drug Regimen Review (QDRR) reports for individuals #686, #723, #700, #525, #459, #596, #542, #570, and #526 6. QDRR Work Sheet, undated 7. Pharmacy & Therapeutics Committee (P&TC) Minutes, April 12, 2011 8. Copy of Emergency Medication Monitoring Database for January 2011, through March 2011. 9. Medication Adverse Drug Reaction Reporting Form (blank), undated 10. Adverse drug reaction forms and supporting documentation for #106, #173, #152, #70, #361, #596, #770 11. Drug Utilization Evaluation (DUE) for benztropine dated October 2011 12. DUE for Lacosamide, dated February 2011 13. Minutes from P&TC that reflect DUE process, dated January 25, 2011 14. Medication Variance Committee Meeting minutes, dated April 12, 2011 15. Facility Medication error/variance policy – undated. 16. Database report for medication variances for March, 2011 17. 43 completed medication variance reports for the month of March, 2001 18. Metabolic Syndrome Monitoring document, undated 19. Last ten medication error reports – per document request

	20. Facility's, Medication error/variance policy **People Interviewed:** 1. AntoParambil, Chief Pharmacist, R.Ph 2. Mike Shatz, Clinical Pharmacist, Pharm. D **Meetings Attended/Observations:** 1. At Risk Team Meetings for Individuals #363 and #385
	Facility Self-Assessment: The Facility reported noncompliance with Provision N.1, of the Settlement Agreement. The Facility reported that pharmacists were trained to review medication orders according to the new medication order review policy and to use a specific checklist that was developed. Pharmacists are now required to review relevant laboratory values before processing any medication order that requires laboratory monitoring. The Facility reported substantial compliance with Provision N.2, of the Settlement Agreement. The Facility continued to use a checklist to review lab results when completing QDRRs. The Facility has hired an additional clinical pharmacist, which will now enable an average of two hours of review per QDRR. The Facility reported noncompliance with Provision N.3, of the Settlement Agreement. The Review Team assessed the Facility'smonitoring of the use of STAT medications, including benzodiazepine, anticholinergics. and polypharmacy. Importantly, the Facility developed a new process for monitoring metabolic syndrome and the physicians and nurses were trained to monitor for metabolic syndrome. Because of the comprehensiveness of the Facility's ability to monitor and follow-up on the use of STAT medications, and implementation of screening for Metabolic Syndrome, the Review Team considers the Facility compliant with Provision N.3, of the Settlement Agreement. The Facility reported noncompliance with Provision N.4, of the Settlement Agreement. The Facility reports in the POI that 90% of recommendations made by the pharmacists are followed by the physician and that appropriate documentation was provided by physicians in the integrated progress notes. During this compliance visit, the Facility provided no data to verify the estimate. The Facility reported noncompliance with Provision N.5, of the Settlement Agreement. In working towards compliance, the Facility has enhanced it's monitoring of DISCUS and MOSES assessments to ensure that they are in the Clinical Records, when scheduled. MOSES and DISCUS reports are reviewed at the time of each psychiatric assessment. The Facility reported non-compliance with Provision N.6, of the Settlement Agreement. The Facility reported that they conduct annual in-services for nurses on reporting Adverse Drug Reactions (ADR) and that ADRs are reported on an ongoing basis. The Facility maintains a process to report ADRs to the FDA, when appropriate. The Facility reported noncompliance with Provision N.7, of the Settlement Agreement. The Facility reports

	providing two DUEs during the past six months and presented results to the P&TC. The Facility reported non-compliance with Provision N.8, of the Settlement Agreement. The Facility launched a new Medication Variance Committee, which meets monthly to oversee trends with medication variances in areas of procuring, storing, dispensing, prescribing and administering medications.
	Summary of Monitor's Assessment: The Monitoring Team was made aware of and verified significant accomplishments by the Facility in enhancing pharmacy services. The Monitoring Team determined that three Provisions in section N, of the Settlement Agreement reached the level of substantial compliance. The Monitoring Team acknowledges the dedication and high level of professionalism demonstrated by all staff who continue to work towards improving services for Individuals served by the Facility. Because of the limited sample size provided and because Pharmacists were not documenting their concurrence with physicians' responses to their recommendations, the Monitoring Team concludes that the Facility is not in compliance with Provision N.1, of the Settlement Agreement. The Monitoring Team noted exceptionally high quality of QDRR reviews at the Facility, and continued with determination that the Facility was in substantial compliance with Provision N.2, of the Settlement Agreement. Furthermore, the Monitoring Team observed exceptional dedication, and performance on the part of the Facility's Clinical Pharmacist, Dr. Shatz. The Facility's hiring of an additional Pharmacist, will enable the Facility to provide enhanced clinical oversight that should realize significant fiscal and clinical benefit to the Facility. Based on the information reviewed, and given the effectiveness of the Facility's process to monitor the use of STAT medications, especially employing an electronic database that enables efficient and effective review of STAT medications, and the fact that the P&T committee effectively reviewed the data to make meaningful decisions, the Monitoring Team has determined that the Facility is in substantial compliance with Provision N.3, of the Settlement Agreement, as long as it updates its database to include individuals' names and formalize a related policy; the Monitoring Team will review at the next compliance visit to ensure this is done. The Monitoring Team compliments all staff involved in this process, and notes the impressive development of its database. The Monitoring Team has determined that the Facility is not in compliance with provision N.4, Although the Monitoring Team clearly recognizes the consistent high quality of the QDRRs and has determined that the pharmacy conducts reviews and makes recommendations to physicians, documentation of follow up by physicians is often missing; therefore, there is no documentation that the pharmacist follows the recommendation to resolution or identifies the need for alternative or additional recommendations. Based on its findings of a lack of an integrated, meaningful system to assess side effects at the Facility, the Monitoring Team concurs with the Facility, and determined that the Facility is not incompliance with Provision N.5, of the Settlement Agreement.

	Although it was evident that the Facility had made efforts in improving its ADR process, because of the lack of appropriate monitoring and documentation following an ADR, the Monitoring Team agrees with the Facility's self assessment and determined that the Facility remains in noncompliance with Provision N.6, of the Settlement Agreement. The Monitoring Team acknowledged the high quality of the DUEs that were offered during the past six months; however, before compliance can be accomplished, the Facility must develop a policy that reflects its process, ensures that meaningful and appropriate recommendations are clearly delineated, and requires that a formal process is in place to provide additional DUEs when clinically necessary, such as when the FDA or manufacturer of a drug initiates a new warning. Also, a robust system must be developed to ensure that outcomes from the DUE are assessed and that competency training is afforded to relevant staff. It is imperative that recommendations become institutionalized at the Facility. For these reasons, the Monitoring Team determined that the Facility remains noncompliant with Provision N.7, of the Settlement Agreement. The Monitoring Team was impressed by the comprehensiveness of the medication error reports and the Facility's new process to address medication variances at the Facility. The new Medication Variance Committee was noted to offer significant insight and meaningful recommendations for medication variances. Importantly, the Monitoring Team was especially pleased to note that all relevant disciplines are taking appropriate action in reporting variances at the Facility. The Monitoring Team was also impressed that staff are beginning to self-report medication variances at the Facility; however, given the number of medications procured for the Facility, number of prescriptions written, drugs dispensed and administered, the Monitoring Team raised concerns of probable under-reporting of medication variances. Importantly, the medication error report form must be completed appropriately and physicians must be more assertive in assessing and monitoring medication errors and adverse events. For these reasons, the Monitoring Team has determined that the Facility is not in substantial compliance of provision N.8, of the Settlement Agreement. Given the Facility's significant efforts towards compliance for this issue, the Monitoring Team is hopeful that the Facility will be found in compliance during subsequent reviews.

#	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	The Facility reported noncompliance of Provision N.1. During an interview with the Pharmacy Director, the Monitoring Team reviewed the new process for ensuring better physician follow-up to single patient interventions (pharmacy interventions). Pharmacy now sends a hard copy of each intervention report to the physician by Facility mail or calls the physician to report a clinical issue with the drug. During the interview, the Monitoring Team was informed that approximately 15 or more interventions are documented each week. The Monitoring Team requested a full week of interventions to review; unfortunately, only three intervention reports were provided for review (Individuals #70, #570, and #526). As noted in Provision N4, physicians did not always document their responses to the interventions and present their rationales, and the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	pharmacist did not follow-up to ensure that clinical rationale was appropriate. In the absence of this documentation, there was no evidence to show that the Pharmacist ensured actions were taken. The Pharmacy Department continues to make significant enhancements with assessing new medication prescriptions. Per interview, training has been provided to dispensing pharmacists on their role and responsibility when dispensing medications. A new policy is being developed that will outline specific practice standards for dispensing medications. Through conversation with the director of pharmacy, the Monitoring Team was informed that dispensing pharmacists, although improving, had yet to completely comply with the new requirements and, on occasion, did not document their review of new medication orders. As explained by the Director of Pharmacy, each order should be stamped by the pharmacist to indicate that the order was reviewed for completeness, and appropriateness. The Monitoring Team noted an example of this reported deficit when reviewing a novel order for Individual #70, for the medication Namenda, which was prescribed on March 11, 2011. There was no indication that the pharmacist reviewed this new order, by their protocol of stamping the order. The Monitoring Team will need to review a larger sample of intervention reports and associated progress notes to determine compliance in the future. Importantly, the Facility must ensure that physicians respond and document clinical rationale and/or follow-up plans in the integrated progress note section of the clinical record and that the reviewing Pharmacist concurs with the Physicians clinical rationale. The Monitoring Team also noticed inherent challenges with maintaining hard copies and physically mailing out copies of intervention reports and monograms to the physician and recommends considering electronic forms of communication.	
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 reports substantial compliance with Provision N.2, of the Settlement Agreement. During the Monitoring Team's previous review, it determined that the Facility was in substantial compliance with the Provision. As part of the current review, the Monitoring Team assessed QDRRs and associated diagnostic reports for the following Individuals: #686, #723, #700, #525, #459, #596, #542, #570, and #526. The Facility hired an additional full time clinical pharmacist, which will now enable an average of two hours for QDRR reviews. The Monitoring Team noted exceptionally high quality of QDRR reviews at the Facility, and continued with determination that the Facility was in substantial compliance with Provision N.2, of the Settlement Agreement. Furthermore, the Monitoring Team observed exceptional dedication, and performance on the part of the Facility's Clinical	Substantial Compliance

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		Pharmacist, Dr. Shatz.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The Facility had recently developed a specific database to track, and enable quality trends analysis, for the use of emergency medications, including benzodiazepines, neuroleptics and other medications, such as anticholinergics. All STAT orders were saved and reviewed by the clinical pharmacist, who then entered the data into the database. Results from the database indicate total number of STAT medications used over any given period of time, specific number of each medication class and percentage of each medication class. The database will be updated in one week from the time of this review, to include the Individual's name. Data are presented and reviewed by the P&T committee each quarter and the committee makes recommendations, when inappropriate use is identified. Since implementing the database, in January of 2011, a total of 20 STAT medications had been provided for behavior issues and reviewed by the P&TC. The Monitoring Team reviewed the Emergency Medication Monitoring Database (Data from January 2011 through March 2011) and P&TC Minutes that reflected review of the database. Despite not having a policy in place, the process was appropriate. Nevertheless, a policy should be developed to ensure the process continues to be carried out. The Monitoring Team reviewed the Facility's guideline for "Metabolic Syndrome Monitoring." The guideline met standard of care, with regards to its recommendations. The Facility should, however, ensure that there is a policy in place or formalize the guideline to ensure its implementation, long-term. Also, the Monitoring Team recommended that a specific metabolic monitoring flow sheet be created and maintained in the clinical record. All individuals who receive medications which can cause metabolic syndrome, even if used on occasion, must be carefully monitoring for the emergence of hyperglycemia, a component of metabolic syndrome. Individuals who were treated with polypharmacy were scheduled for PBMC review every month. Review of polypharmacy at the PBMC was detailed. Psychotropic medications were listed, laboratory and pharmacy information was reviewed by the clinical pharmacist, and side effect scales were reviewed by the RN. Based on the information reviewed, and given the effectiveness of the Facility's process to monitor the use of STAT medications especially employing an electronic database that enables efficient and effective review of STAT medications, and the fact that the P&T committee effectively reviews the data to make meaningful decisions, as well as the monitoring of metabolic syndrome, as well as the review of polypharmacy, the	Substantial Compliance

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		Monitoring Team has determined that the Facility is in substantial compliance with Provision N.3, of the Settlement Agreement. At the next compliance visit, the Monitoring Team will review to ensure the Facility updates its database to include individual's names and formalize a related policy. The Monitoring Team compliments all staff involved in this process, and notes the impressive development of its database.	
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.	The Facility informed the Monitoring Team that it remains non-compliant with Provision N.4, of the Settlement Agreement. To assess compliance, the Monitoring Team reviewed QDRRs for the following individuals: #686, #723, #700, #525, #459, #596, #542, #570, and #526. The Monitoring Team clearly recognizes the consistent high quality of the QDRRs. Unfortunately, despite the high quality and meaningful QDRRs, and 100 percent (9/9 of QDRRs reviewed) concurrence with physicians' responses to pharmacists' recommendations, physicians did not document in the integrated progress notes their clinical justification and follow-up action. Therefore, there is no way to verify the estimate in the POI that 90% of recommendations made by the pharmacists are followed by the physician. Nevertheless, because there was agreement in sampled QDRRs on all recommendations from the pharmacist, and therefore no way to determine whether documentation would have occurred if there had not been agreement, this provision is rated in Substantial Compliance. Although not required by this provision, the Monitoring Team recommends that clinicians clearly document their clinical justification, and follow-up plan for each issue addressed by the clinical pharmacist.	Substantial Compliance.
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The Facility acknowledged that it remains noncompliant with Provision N.5, of the settlement Agreement. Pharmacy did not take an active role in training of staff with regards to side effect monitoring of medications, including training on the MOSES, or DISCUS. Pharmacists were not trained on the MOSES or DISCUS. According to the Director of Pharmacy, there is no process in place to conduct inter-rater reliability for completing the MOSES, or DISCUS. More frequent assessment for side effects are not routinely conducted. To assess the Facility's ability to ensure side effect monitoring, the Monitoring Team requested a list of all individuals who underwent a recent addition or discontinuation of a neuroleptic medication, as well as all individuals who had a dose change of their neuroleptic, along with 12 months of DISCUS and MOSES reports. The Facility responded by indicating that they "do not keep records on new antipsychotics started" but provided	Noncompliance

#	Provision	Assessment of Status	Compliance
		a hand written list of such medication changes. Unfortunately, associated DISCUS and MOSES assessments were not provided to the Monitoring Team for review. Without tracking of additions and discontinuations of neuroleptic medications, the Facility misses a useful way to determine that assessment for TD is done not only quarterly, but also "as needed" as required by this provision. It is imperative that a comprehensive side effect monitoring process be developed and well implemented at the Facility. Pharmacy must ensure that all relevant staff are trained on assessing for side effects, especially on all side effect assessment tools used at the Facility. Inter-rater reliability testing must be routinely assessed and all nurses, physicians, psychologists and pharmacists, who rely on data from assessment scales, must be trained on their use so that they understand the diagnostic they rely on for making treatment decisions. Pharmacy must ensure that all individuals are regularly assessed for side effects, including TD, as clinically indicated and not just routinely. Based on its findings of a lack of an integrated, meaningful system to assess TD at the Facility, the Monitoring Team concurs with the Facility, and determined that the Facility is not incompliance with Provision N.5, of the Settlement Agreement.	
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 reported that it remains non-compliant with Provision N.6, of the Settlement Agreement. The Monitoring Team recognized that the Facility, under the leadership of the Pharmacy Director and Clinical Pharmacist, had made significant efforts in working towards compliance. For example, the Facility reported that all ADR reports are followed up by the Clinical Pharmacist, and a copy of the ADR is placed in the active record. Nevertheless, following review of ADRs, the Monitoring Team raised concern over the quality of response to ADRs by nursing and physician staff: 1. A Pharmacist reported potential adverse reaction to medication (valproic acid), to the clinical pharmacist for evaluation. Physician and nursing services did not appropriately document the issue in integrated progress notes. 2. A Pharmacist noted individual #152 experienced hyponatremia with the medication oxcarbamazepine, and reported the issue to the clinical pharmacist. Oxcarbamazepine was tapered while valproic acid was titrated up. The physician and nurse did not appropriately document the issue. 3. An adverse drug reaction was reported by living area nurse who identified a hypotensive event on Individual #70, following administration of i.vativan. Appropriate action clinical action was initiated. Physician did not document	Noncompliance

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		event. 4. For individual #173, severe thrombocytopenia developed following initiating valproic acid. Physician notified pharmacy to discontinue medication and add valproic acid to allergy list. The Monitoring Team questions whether this was a true allergy or adverse affect to the drug. Appropriate distinction is important for future clinical decision making. Also, appropriate follow-up and documentation was not observed in review of the integrated progress notes. 5. For Individual #361, the physician noted a hypotensive event with syncope and daytime sedation, which was attributed to an antipsychotic medication. The physician discontinued the medication and initiated an allergy alert to the medication. The Monitoring Team questions whether this was a true allergy or adverse affect to the drug, as there was no documentation that syncope was evaluated for other possible cause. Appropriate distinction is important for future clinical decision making. Also, appropriate follow-up and documentation was not observed in the integrated progress notes. 6. For Individual #596, the nurse practitioner noted an elevated CPK level that was suspected to be secondary to a medication. The medication was discontinued and follow-up CPK level and lipid panel was ordered for three months afterward; an elevated CPK can indicate a serious condition (such as cardiac issues that can be life-threatening) and should be followed closely. The Monitoring Team was concerned that a differential diagnosis for the elevated CPK (such as ischemic heart disease) was not entertained and the prolonged period before re-checking the CPK level. Documentation to demonstrate close clinical monitoring for the elevated CPK was not provided to the Monitoring Team. 7. For Individual #770, the pharmacist noted thrombocytopenia following administration of valproic acid. The nurse practitioner noted on the ADR to reduce valproic acid dose, and follow-up with labs, monitor for increase seizure activity, and monitor the individual closely. The order generated by the nurse practitioner was to prescribe extended release Depakote. Orders to enhance monitoring and for labs were not initiated at the time of making the dose change. Progress notes did not reflect close monitoring. Furthermore, there was no documentation of exploration of other potential causes of thrombocytopenia. Although not required for compliance with this provision, the Monitoring Team reviewed follow up from QDRRs as well as from adverse drug reactions reported at other times. As noted in the examples arising from adverse drug reactions, the Monitoring Team is	

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		concerned that follow up should be thorough, and physicians should provide rationale for decisions. Despite the high quality of the QDRRs, the lack of documentation of follow up from the QDRRs and of rationale for physician decisions is concerning, as there is no way to determine that the pharmacist follows the recommendation to resolution or identifies the need for alternative or additional recommendations. For the past six months a total of thirty ADRs were officially reported to pharmacy through the Facility's ADR process. The Monitoring Team recognized that there was a significant improvement in reporting, when compared to past reviews. However, based on review, the Monitoring Team noted that direct care staff were not reporting potential ADRs to nursing staff for assessment. Also, Facility Clinicians and Nursing staff must enhance their documentation, and monitoring practice for ADRs. Although it was evident that the Facility had made efforts in improving it's ADR process, because of the lack of appropriate monitoring and documentation following an ADR, the Monitoring Team agrees with the Facility's self assessment and determined that the Facility remains in non-compliance with Provision N.6, of the Settlement Agreement.	
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.	The Facility reported to the Monitoring Team that it is not in compliance with Provision N.7, of the Settlement Agreement. The Facility did not have a specific policy for their Drug Utilization Evaluations (DUEs). The Pharmacy Director outlined the Facility's DUE process for the Monitoring Team. According to the Pharmacy Director, the P&TC makes a selection on four drugs to conduct a comprehensive DUE for the entire year. This selection is based on the usage, commonly used drugs, and high risk drugs such as those with narrow therapeutic windows. Any member of P&TC can recommend a drug to be reviewed. There was no formal process to select DUEs. DUEs had been done since 2009 and there had been two DUEs since the prior compliance visit. Review of P&TC minutes, dated January 25, 2011, indicated that four DUEs were chosen for the upcoming year. The minutes also reflected that a DUE for Benztropine was developed by Dr. Shatz and clearly outlined highlights of that DUE. The Monitoring Team reviewed two DUEs that were developed by the Facility's Clinical Pharmacist, Dr. Shatz. Both the DUE for Benztropine and lacosamide demonstrated a high level of professional development.. The DUEs were clinically relevant to the Facility, clearly documented appropriate utilization data, and provided a current review of the literature and guidelines. The Monitoring Team noted that more assertive recommendations were warranted for the Benztropine DUE. The Pharmacy Director indicated that there was no current mechanism to monitor	Noncompliance

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		outcomes of recommendations of DUEs, nor was a competency based training venue available to ensure appropriate staff are well trained on recommendations. There was no formal mechanism for additional DUEs to be initiated, in the event of unexpected adverse outcomes from drug utilization at the Facility or in the event of a sudden recall or new warning. The Monitoring Team acknowledged the high quality of the DUEs that were offered during the past six months. Before compliance can be accomplished, the Facility must develop a policy that reflects its process, ensures that meaningful and appropriate recommendations are clearly delineated, and requires that a formal process is in place to provide additional DUEs when clinically necessary, such as when the FDA or manufacturer of a drug initiates a new warning. Also, a robust system must be developed to ensure that outcomes from the DUE are assessed and that competency training is afforded to relevant staff. It is imperative that recommendations become institutionalized at the Facility. For these reasons, the Monitoring Team determined that the Facility remains non-compliant with Provision N.7, of the Settlement Agreement.	
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.	The Facility informed the Monitoring Team that it remained out of compliance with Provision N.8, of the Settlement Agreement. The Facility is working diligently on enhancing its medication variance process. The Facility had conducted monthly meetings to oversee the trends in the medication variance in procuring, sorting, dispensing, prescribing and administering drugs. The Facility developed a database to collect data that reflects information on the medication error form. The Facility had developed a medication variance committee, chaired by the Director of Pharmacy. The medication variance committee had met every month for the past three months. Membership consisted of pharmacy, nursing, physician, dental, and psychiatry staff. The Committee reviewed trends for medication variances from all disciplines (pharmacy, dental, physician and nursing services). Remedial action was to be provided by the specific department head. Review of Minutes from the Medication Variance Committee, dated April 12, 2011, demonstrated a general review of medication variances at the Facility. A Total of 43 variances were reported (25 from nursing services, 8 from physician services, and 10 from pharmacy), during the past 12 months. The modes of variances included procurement, stocking, prescribing, dispensing and administration. There was a robust database to track trends of variances at the Facility. Remedial action was documented.	Noncompliance

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		At the time of its review, the Monitoring Team reviewed the Facility's database report for medication variances. The new policy specific for Medication ERROR/VARIANCE (Medication Error/Variance Policy) was reviewed by the Monitoring Team. Of the ten medication error reports submitted through the document request, the following issues were identified by the Monitoring Team: • Of the last 10 medication errors submitted through document request, seven (70%) were committed by the nursing staff and three (30%) were committed by the pharmacy staff. • One of six (17%) medication errors committed by the nursing staff contained notification of physician. • None of three (0%) medication errors (dispensing) committed by the pharmacy staff contained notification of the physician. They were Category A: Circumstances or events that have the potential to cause error. • There is an item on the form to document the physician was notified of the error. One of 10 (10%) Medication Error Reports contained notification of physician. According to RSSLC's Medication Errors Policy, 01.05.20, #2, "When a medication error is detected, "Medication Error Data Entry" form shall be filled out at once by the individual who has detected the error." This includes completing the item on the Medication Error Data Entry form that documents that the individual's physician was notified of the medication error. It is essential that the physician be notified of the error so the physician can determine what action, if any, must be taken. The Facility needs to ensure that the physicians are always notified of medication errors and that the notification and physician's response are documented on the Medication Error Data Entry Form. • The policy for medication variances is not specific with regards to physician involvement. Physicians must take an active role in assessing and monitoring of the individual. The Monitoring Team was impressed by the comprehensiveness of the medication error reports and the new process to address medication variances at the Facility. The new Medication Variance Committee was noted to offer significant insight and meaningful recommendations for medication variances. Importantly, the Monitoring Team was especially pleased to note that all relevant disciplines are taking appropriate action in reporting variances at the Facility. The Monitoring Team was also impressed that staff are beginning to self-report medication variances at the Facility; however, given the number of medications procured for the Facility, number of prescriptions written, drugs dispensed and administered, the Monitoring Team raised concerns of probable under-reporting of medication variances. Importantly, the medication error report form must be completed appropriately and physicians must be more assertive in assessing and monitoring medication errors and adverse events. For these reasons, the Monitoring	

#	Provision	Assessment of Status	Compliance
		Team has determined that the Facility is not in substantial compliance of provision N.8. Nevertheless, given the Facility's significant efforts towards compliance for this issue, the Monitoring Team is hopeful that the Facility will be found in compliance during subsequent reviews.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Ensure that physicians document their response, clinical rationale, and follow-up plan in the integrated progress notes, for their response to drug interventions.
2. Ensure that a meaningful Policy is developed on the Facility's monitoring of STAT medications and ensure that the database is updated to reflect Individual's identifiers.
3. Ensure that physicians routinely document their clinical justification, along with follow-up plan for all QDRR recommendations.
4. Clinical staff must enhance its ability to appropriately document ADRs and enhance clinical monitoring of individuals following an ADR.
5. Policy that clearly outlines the purpose and entire process of the DUE program must be developed, including a formal mechanism to ensure that a prompt and additional DUE can be developed in the event of clinical need or secondary to new warning by the FDA or manufacturer of a drug.
6. Ensure that outcomes are assessed for recommendations made by a DUE.
7. Ensure that there is a formal process to provide competency based training for all relevant staff secondary to recommendations issues by a DUE.
8. Continue to enhance self reporting of medication variances at the Facility.
9. The Facility must immediately enhance side effect monitoring of medications at the Facility.
10. Pharmacy must ensure that all relevant staff are training on assessing individuals for side effects of medications.
11. Pharmacy must ensure that all relevant staff, including physicians, pharmacists, psychologist and all nurse are trained on the use of side effect assessment tools (MOSES and DISCUS).
12. Pharmacy must ensure that all individuals are regularly assessed for side effects, including TD, as clinically indicated and not just routinely.
13. Develop policy or formalize the metabolic monitoring screening process.
14. It would be advantageous to develop a database to track and enable longitudinal analysis of ADRs

The following are offered as additional suggestions to the facility:

1. Consider sending out copies of drug interventions/monograms to physicians electronically.

2. It would be helpful if QDRR recommendations and physician responses are periodically assessed for appropriateness. This would help ensure on-going quality outcomes.

3. The Facility should consider including a process to evaluate the effectiveness of medication side effect monitoring as part of the medication variance committee
4. Consider developing and implementing a specific flow sheet for metabolic screening, that is maintained in the clinical record.

5. Consider establishing inter-rater reliability checks to ensure staff who administer the MOSES and DISCUS, and those clinicians who rely on data from such instruments for clinical decision making, are aware of how to appropriately administer the instrument and interpret data generated by the instruments.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Plan of Improvement, (POI) 04/18/2011 2. Record reviews for Individuals #6, #16, #84, #109, #149, #283, #316, #322, #347, #385, #471, #512, #573, #771 and #784 3. A list of all therapy and/or clinical staff (OT, PT, SLP, RD,), and Physical and Nutritional Management (PNM) team members, including credentials 4. Policies, procedures, and/or other documents related to Physical and Nutritional Management (Policy K.1 dated 3/21/2011) 5. Curriculum vitae (CVs) for PNMT members 6. A list of continuing education sessions or activities participated in by PNMC members since 10/2010 7. Minutes, including documentation of attendance, for the following meetings • Pneumonia committee (11/22/10 to 2/16/11) • Integrated weekly Meeting (11/10 to 3/10) 8. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order for sample 9. Tools used to assess PNM status and needs 10. A list of PNM assessments and updates completed in the last two (2) quarters 11. Tools used to monitor implementation of PNM procedures and plans 12. A list of individuals for whom PNM monitoring tools were completed in the last quarter 13. Tools utilized for validation of PNM monitoring 14. 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 15. Nutritional management plan template and any instructions for use of template 16. Dining Plan template 17. List of Nutrition consults 5/2/11 18. 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 October 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 19. Videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation during the past year 20. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 21. Tools and checklists used to provide competency-based training addressing: (a) Foundational skills in PNM; and (b) Individual PNM and Dining Plans 22. Information on percent of staff with responsibilities for the provision of direct supports who have completed competency-based training on foundational skills in PNM 23. Oral Hygiene Plan Draft **People Interviewed**: 1. PNM Team (David Taylor OTR, Jean Cuevo PT, Sally Martinez RN, and Brandy Rabe SLP) 2. DCPs (Three-Trinity, Three-Leon, Three-San Antonio, Two-Neches) **Meetings attended/ Observations of**: 1. Meals on Trinity, Leon, and San Antonio 2. Transition times (Leon, San Antonio) 3. Medical Nutrition Therapy Meeting 5/2/11 4. Pneumonia Meeting 5/3/11 5. PSP for Individual #477 6. At Risk Team Meeting for Individuals #363 and #385
	Facility Self-Assessment: For Provision O.1, the Facility stated they are not in compliance with this provision. RSSLC stated that since the last compliance review (10/2010), the Physical and Nutritional Management Team (PNMT) invited campus nurses, unit directors, MDs, and management staff to participate in the Aspiration Pneumonia Committee meetings. Per review, The PNMT had not been meeting and the Aspiration Pneumonia Committee was not clearly defined in their role or purpose. For Provision O.2, the Facility stated they are not in compliance with this provision. RSSLC stated the team had not performed assessments due to its role in the Aspiration Pneumonia Committee. The PNM team are scheduled to add a dedicated Speech Pathologist (SLP), Physical Therapist (PT), Occupational Therapist (OT) and Nurse (RN) to its team. Missing from the self assessment was information regarding identification of the those at risk of physical and nutritional decline as well as the lack of clear justification in the completed assessments. For Provision O.3, the Facility stated they are not in compliance with this provision. RSSLC reported that

	statements regarding positioning for oral care and medication administration were added to PNMPs for individuals who were at a high risk for aspiration and choking and that staff will be trained on changes to plans. 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. For Provision O.4, the Facility stated they are not in compliance with this provision. RSSLC stated that monitoring occurs by PNMP coordinators, therapists, and home supervisors to ensure proper mealtime practices are incorporated into each meal. Issues that occur are followed through with therapists as needed. However, based on observation of mealtimes, staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. Monitoring was not accurate and follow-through did not ensure proper practices occur. 100% of direct care and home supervisors have completed refresher training in PNM. For Provision O.5, the Facility stated they are not in compliance with this provision. RSSLC stated that a PNM course has been developed for all direct care staff to use on an annual basis and was scheduled to be on computer by the end of April. As of this review, the PNM course had not been implemented as computer based training. Per POI, all staff had been provided with competency based PNM training and all staff received annual PNM refresher training. In addition to the PNM training, staff also receive annual refreshers regarding Ambulation, and Lifting/Transfers. The claim of the POI was unable to be verified due to RSSLC not having a clear system to track staff trainings and therefore identify who had and who had not received the training. For Provision O6, the Facility stated they are not in compliance with this provision. RSSLC stated that mealtime and positioning plans occur at every meal by habilitation staff. A comprehensive monitoring form for both monitoring and validity checks had been approved by the state. Although the form is comprehensive, monitoring of implementation did not cover staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). Monitoring remained highly focused on mealtime. Additionally, there was no clear policy or process that clearly defined responsibilities as well as the schedule of monitoring., For Provision O.7, the Facility stated they are not in compliance with this provision. RSSLC stated that individuals identified as being high risk of choking and/or aspiration pneumonia are monitored at least once a week for all parts of their PNMP. Quality Assurance (QA) monitor trained OT/PT staff and distributed Section O monitoring tool. Per review, there was no clear policy or process that clearly defined responsibilities as well as the schedule of monitoring.,

	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. For Provision O.8, the Facility stated they are not in compliance with this provision. RSSLC stated that an Aspiration Pneumonia-Enteral Nutrition Evaluation was implemented and all individuals receiving enteral nutrition will receive an evaluation at the time of their annual review or in the occurrence of aspiration pneumonia. The Monitoring Team noted that individuals who were enterally nourished had not received an assessment that addressed the medical necessity of the tube and potential pathways to oral (PO) status. The self-assessment of noncompliance in all sections was consistent with the Monitoring Team's assessment of noncompliance with this provision.
	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 not meeting and did not have any clear center-based policy identifying their roles and responsibilities. RSSLC did have a Pneumonia Committee that focused more on systems issues but did not address issues regarding aspects of PNM outside of aspiration pneumonia. Additionally, there was a lack of structure during the Pneumonia committee resulting in lack of clear action plans to address identified issues. **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 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. 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 Bed elevation is generally assigned and is not clearly based on assessment. Per Director of Habilitation Services, this is an area that will be a focus moving forward. **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. 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 implementation was not effective. Additionally, PNM supports for individuals who are determined to be at an increased level of risk were not provided only 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 an individual or that there was 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. A new monitoring form was developed that focuses on PNM risks throughout the individual's day. The new document covers the areas of meals, snacks, oral care, medication administration, and positioning. Although the form is comprehensive, monitoring implementation did not cover staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). Monitoring remained highly focused on mealtime. A policy and schedule that will ensure all areas are focused on should be developed. **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. The PNM Team did not document progress of individual strategies on a consistent 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 had not received an assessment that addressed the medical necessity of the tube and potential pathways to oral (PO) status. There were, however, several practices related to the PNMP that the Facility should ensure continue,

	• Positioning instructions for wheelchair and alternate positions instructions were included as applicable. • Transfer instructions were included as applicable. • Mealtime/dining plan included intake information for mealtime and snacks. • Mealtime/dining plan included food/fluid textures as applicable. While the addition of an aspiration trigger data sheet and development of a pneumonia committee are potentially positive additions since the last review, there remained a lack of direction regarding the PNM process and how it fits into improving the overall care of the individual. The lack of direction may be a result of tremendous turnover as RSSLC had lost five SLPs and the Director of Habilitation Services since the last visit. However, RSSLC must find a way to move past these obstacles and begin to make substantial improvements regarding this section. Until this can be accomplished, individuals will continue to be placed at an unnecessary risk. Overall, there was a decline in the level of care since the previous visit. Individuals who were experiencing PNM related issues were not being adequately cared for as evidencedby the lack of detailed assessment as well as lack of an adequate team process and discussion.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary,	Per interview with the David Taylor (one of two persons serving as Acting Habilitation Director), the PNM team (PNMT) at RSSLC will consist of a dedicated Speech Language Pathologist (SLP), Occupational Therapist (OT), Physical Therapists (PT), and Registered Nurse (RN). Ancillary members include physician (MD), Registered dietitian (RD) and Psychologist. As of this review, the OT, and PT were still carrying caseloads and the SLP had just completed orientation; therefore, the PNMT had not included all necessary members on a consistent basis. The PNMT had not met to discuss or provide input or assistance to the PST regarding episodes relevant to physical and nutritional supports (i.e., falls, aspiration, or choking) since the last compliance review. Per interview with the PNMT, a formal process or policy did not exist at the center level that guides the team regarding its roles and responsibilities. In addition to the PNMT, RSSLC had a Pneumonia committee that consisted of Habilitation Services (OT, PT, SLP), Nursing, Medical director, Quality Assurance, Infection control, Dental, Food Services, Unit Directors and QMRPs. Based on a review of Pneumonia committee attendance records and meeting minutes dated 11/22/10 to 2/15/11, core participation was noted by the Habilitation Director, Physical Therapist, Occupational Therapist, Speech Pathologist, Dietitian, RN Case	Noncompliance

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	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.	Manager, Infection Control Nurse, QA and Medical Director. Observation of the Pneumonia Committee meeting on 5/3/11 and review of minutes from 11/22/10 to 2/16/11 indicated the core focus of the meetings was to look at systems issues and what can be done on a systems level to address aspiration pneumonia. There was no evidence that the Pneumonia Committee looked at individual PNM issues or served as a resource to the PST. Per observation of the Pneumonia committee meeting on 5/3/11, overall systems issues were discussed but there was little direction regarding who was responsible for what tasks or if tasks or action plans were clearly assigned. The meeting had the appearance of an informal discussion rather than a meeting designed to identify issues and provide clear resolutions to the identified issues. RSSLC also had an Integrated Weekly Meeting that consisted of multiple disciplines. Based on review of Integrated Weekly Meeting minutes from January 2011 to April 2011, core participation consisted of the physicians as well as members of nursing and habilitation services. The focus of the meeting was not based solely on issues relevant to PNM but focused on a variety of medical issues. There was no evidence that the Integrated Weekly Meeting focused on individual PNM issues that had occurred since the previous meeting or that it served as a resource to the PST. Review of facility documentation--Curriculum Vitae(s), copy of current licenses--submitted for each PNM Team standing member did demonstrate the following qualifications for PNM Team standing members: • In four of four licenses reviewed (100%), a copy of the license was current. • In four of four CVs reviewed (100%), experience in respective field was documented. Review of PNM clinical instruction documentation submitted to the Monitoring Team revealed that PNM Team members did have training and professional development in the following areas: • In four of four individual clinical instruction records reviewed (100%), clinical instruction related to physical and nutritional supports had been completed within the last 12 months. Based on a review of 15 individual records, documentation supported that the PNM Team or PST did not meet regularly to address change in status, indicators of increased risk, clinical data and monitoring results.	

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		Individual examples of where the PNM Team or PST did not meet regularly to address change in status, assessment, clinical data and monitoring results included: • Individual #6 was diagnosed with aspiration pneumonia on 7/5/10. There was no PST or PNMT response to the incident. • Individual #16 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 #84 was diagnosed with aspiration pneumonia on 5/21/10 and 1/6/11. 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 or PST met to discuss the issue. • Individual #347 had a choking event on 11/14/10. There was no evidence of a comprehensive oral motor assessment to determine if there was a decline in swallow function. • Individuals #149, #322, 512 had swallow studies completed but there was no evidence of PST or PNMT review of findings. Additionally, members of the PST did not consistently attend meetings in which their expertise is most needed. For example, 1. Individual #385 was diagnosed with aspiration pneumonia on 11/3/10. There was no evidence of OT or SLP involvement in the PST meeting on 11/1/10 or 12/3/10. Lack of participation results in the individual not receiving a comprehensive review in response to a change in status.	
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	A process was not in place that consistently identifies individuals with PNM concerns. Three of 15 records (20%) reviewed accurately identified individuals who are at an increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified included: • Individual #283 had aspiration pneumonia on 11/9/10 but was listed as being only at a moderate level of risk. • Individual #316 had a choking event on 8/23/10 but was listed as moderate risk. • Individual #109 had a choking event on 2/17/11 but was listed as low risk. • Individual #573 had a diagnosis of dysphagia, was on a g-tube, and was receiving trial feedings but was listed as low risk.	Noncompliance

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	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.	Risk guidelines were not being followed nor was there evidence of why the team assignment of risk varied from the provided state guidelines. Per the risk list provided to the monitoring team, it was noted that there were only four individuals identified as being at a high risk of aspiration. Based on the population living at RSSLC and the observations conducted, this number did not accurately represent those who are at risk. Based on a review of 15 individuals, zero of 15 individuals (0%) were provided with a comprehensive assessment by the PNM team that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake. The Occupational Therapy (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 #471's OT/PT assessment 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 #6's OT/PT assessment 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 #316 who choked on a pill during medication 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 are 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. Examples of this issue may be found in the record of Individual #771. Review of 15 records revealed: • In zero of 15 records reviewed (0%), there was documentation of PNM review/analysis of the findings, including but not limited to relevant discipline-specific assessment(s), PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary. The summary did not address:	

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		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 Bed elevation is generally assigned and is not clearly based on assessment. For example, an individual who has GERD and no skeletal abnormalities would be recommended the same degree of elevation as someone with severe skeletal abnormalities. Per Director of Habilitation Services, this is an area that will be a focus moving forward. Individuals who received direct and indirect PNM and OT/PT supports received annual OT/PT assessments in addition to medical, and nursing. 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. In zero of 15 records reviewed (0%), there was congruency between Strategies/Interventions /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 #403 should have liquids held until the end of the meal but there was no description as to what swallowing issues this strategy addressed. • Individual #251 should be offered drinks at the beginning. 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. Lack of description leads to lack of staff knowledge.This increases the risk of aspiration or choking because PST members may not identify ways to integrate their own recommendations to support these recommendations and staff do not know what to observe and report and may not implement recommendations accurately. The Aspiration Trigger data Sheet was implemented for all individuals. The trigger data sheet was designed to monitor the presence or absence of triggers related to potential aspiration.	

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		The development of this data sheet is another positive step forward in better being able to identify signs and symptoms. The issue with this existing data sheet included: • Lack of individualized triggers • Lack of notification of all occurring triggers. For example, a trigger may not be documented or nurse notified if the trigger stopped occurring after repositioning or plan implementation.	
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 strategies and medication administration. Per Dental, an Oral Hygiene Plan was being developed that will contain strategies but RSSLC might be better served if this information was added to the PNMP rather than the development of an additional form. Based on a review of 15 individual PNMPs, individuals were not provided with a comprehensive PNMP. • In zero of 15 PNMPs reviewed (0%), strategies for medication administration were included. • In zero of 15 PNMPs reviewed (0%), strategies for oral hygiene were included. • In zero of 15 PNMPs (0%), head of bed elevation contained the degree in which the person should be elevated. • In zero of 15 PNMPs reviewed (0%), clinical indicators associated with PNM decline were present. There were, however, several practices that the Facility should ensure continue, • In 15 of 15 PNMPs reviewed (100%), positioning instructions for wheelchair and alternate positions instructions were included as applicable. • In 15 of 15 PNMPs reviewed (100%), transfer instructions were included as applicable. • In 15 of 15 PNMPs reviewed (100%), the mealtime/dining plan included intake information for mealtime and snacks. • In 15 of 15 PNMPs reviewed (100%), the mealtime/dining plan included food/fluid textures as applicable. • In 15 of 15 PNMPs reviewed (100%), the mealtime/dining plan included behavioral concerns related to intake. • In 15 of 15 PNMPs reviewed (100%), individual adaptive equipment was included.	Noncompliance

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		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. Oral Care was in the process of being added to the PNMPs but was not sufficiently implemented to determine if appropriate. Based on the PNMPs reviewed, information regarding oral care was limited to positioning and did not contain information on how to best and most safely provide supports during this activity. In 15 of 15 records reviewed (100%) PNMPs were incorporated into the Personal Support Plan, but as mentioned previously, the PNMPs were not comprehensive as they did not consistently contain information regarding oral care and medication administration as well as specifics regarding head of bead elevation, nor were there signs of integration across disciplines with the exception of OT and PT. In 15 of 15 records reviewed (100%), there was evidence that the PNMPs were reviewed annually at the PSP meeting. In five of 15 records reviewed (33%), it was clear as to whether the PNMPs were updated as needed; in the others, lack of updating was due to at times to 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 #6 was diagnosed with aspiration pneumonia on 7/5/10. There was no PST or PNMT response to the incident. • Individual #16 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	
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	Based on observation of mealtimes, staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. Four mealtime 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 two of 18 individualobservations(11%), staff were following mealtime plans. • In 12 of 18 individual observations(67%), staff were following wheelchair positioning instructions.	Noncompliance

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	administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	• In six of six individual observations (100%) staff were following transfer instructions, Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included: • Individuals # 601, #465, and #154 were observed overstuffing their mouths during meals without cueing from staff to decrease bite size as stated per dining plan. • Individual #644 was observed being fed with his neck severely hyperextended resulting in an increased risk of aspiration secondary to an exposed airway. The plan called for his head to be in a neutral position. • Individual #251 was not provided with liquids at the beginning of the meal or throughout the meal as stated per plan. • Individual #471 who had a recent diagnosis of aspiration pneumonia was not provided with alternating liquids and solids or cues to slow down the rate of intake resulting in an increased risk of choking and/or aspiration. Per interview with three DCPs on Trinity, three DCPs on Leon, three DCPs on San Antonio and two DCPs on Neches, most staff understood various techniques designed to ensure safe eating and positioning but did not consistently understand the rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP. • In nine of 11 interviews with staff,(81%) staff could identify the location of PNMP and/or mealtime plan. • In six of 11 interviews with staff (54%), staff could describe individual-specific PNMP strategies. • In four of 11 interviews with staff (36%), 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 six of 11 interviews with staff (54%) , staff stated they had received individual-specific training for PNMP strategies. • In three of 11 interviews with staff (27%), staff were able to explain the importance of the aspiration trigger data sheet. Examples of direct support professionals who were not able to describe the following PNMP indicators: • DCPs on San Antonio and Trinity stated that strategies to mitigate the risk associated with aspiration were limited to mealtimes. • DCP on Trinity was not able to state why alternating liquids and solids decreased	

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		the risk of choking	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	Staff were provided with general competency-based foundational training related to all 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 POI, all staff had been provided with competency based PNM training and all staff received annual PNM refresher training. In addition to the PNM training, staff also receive annual refreshers regarding Ambulation, and Lifting/Transfers. The claim of the POI was unable to be verified due to RSSLC not having a clear system to track staff trainings and therefore identify who had and who had not received the training. If RSSLC was unable to verify to the Monitoring Team, it was unclear as to how RSSLC could be certain that all staff had received the needed training. In addition, RSSLC had submitted a PNM refresher course to be developed as an I-learn course. Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by test, which may also include return demonstration as applicable. By report, return demonstration or skills based competency based check offs are limited to the lifting and transfers class. All other areas of PNM are scored based on a multiple choice test. Staff were to be 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 are then responsible to train their staff. The therapy department maintained documentation of the home supervisors' training, and sign-in sheets for in-services provided to direct care staff were maintained by the home. Staff training provided was not consistently competency-based.	Noncompliance

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		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. Additionally, PNM supports for individuals who are determined to be at an increased level of risk were not provided only by staff who have successfully completed competency-based training specific to the individual. There was not a clear process in place that ensures all staff (including pull staff) are provided with person-specific competency based training prior to working with the individual orthat there was a method in place that helps the supervisors identify staff who have received the needed individualized training.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	A new monitoring form was developed that focuses on PNM risks throughout the individual's day. The new document covers the areas of meals, snacks, oral care, medication administration, and positioning. Although the form is comprehensive, monitoring implementation did not cover staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). Monitoring remained highly focused on mealtime. The monitoring processes remained highly informal and without clear direction regarding what areas require monitoring and to what frequency all areas should be monitored. A review of 80 Facility monitoring reports from January to March 2011 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 consistently monitored: • Medication Administration • In-Bed Positioning • Bathing Examples of PNM activities that were being monitored: 1. Mealtime Interventions 2. Mealtime Positioning 3. Adaptive Equipment 4. Oral Care 5. Positioning during Oral Care	Noncompliance
O7	Commencing within six months of	A process was not in place that promotes the discussion, analysis and tracking of	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	individual status and occurrence of health indicators associated with PNM risk. Based on the review of 15 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. While PNMPs are reviewed at the PSP, there was not a system in place that clearly monitored the overall effectiveness of the plan. Aspiration Trigger Data sheets had been implemented that allowed for the tracking of clinical indicators but there was not a system that allowed for review and analysis of the acquired data. The PNM team was not meeting; therefore, the Monitoring Team was unable to review whether or not the team utilized PNMP monitoring information in their reviews. 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.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	Review of four individuals who were enterally nourished revealed these individuals did not receive an assessment that addressed the medical necessity of the tube and potential pathways to PO status. Examples of individuals who received enteral nutrition and did not receive an assessment were individuals #16 and #385. Four of four individuals with a PNMP (100%) who received enteral nutrition 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 or identify or investigate potential return to oral intake or methods to improve oral motor functioning. Improvement of oral functioning is important not only because it increases the likelihood of a potential return to oral intake but also because it improves the individual's ability to control and tolerate their own secretions.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The state had developed an Aspiration/enteral nutrition evaluation that was intended to address this area but this document had not been implemented as of this review.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The PNM team consisted of qualified SLP, OT, PT, RD, and 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 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.
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. All individuals who are determined to be at an increased risk should be provided assistance only 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.
7. All developed processes 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).
8. 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.
9. 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.
10. 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.
11. An assessment should be developed that focuses solely on swallowing since this is an issue that is a major focus of decline. Observations of mealtime are vague and do not provide the objective detailed data to be considered an appropriate assessment.
12. Per Dental, an Oral Hygiene Plan was being developed that will contain strategies but RSSLC might be better served if this information was added to the PNMP rather than the development of an additional form.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Plan of Improvement, (POI) 04/18/2011 2. Record reviews for Individuals #6, #16, #17, #84, #95, #109, #142, #149, #199, #283, #316, #322, #347, #385, #426, #471, #487, #512, #573, #597, #601. #677, #683, #693, #771 and #784 3. A list of all therapy and/or clinical staff (OT, PT, SLP, RD,), and Physical and Nutritional Management (PNM) team members, including credentials 4. Policies, procedures, and/or other documents related to Physical and Nutritional Management (Policy K.1 dated 3/21/2011) 5. Curriculum vitae (CVs) for OTs and PTs 6. A list of continuing education sessions or activities participated in by PNMC members since 10/2010 7. Minutes, including documentation of attendance, for the following meetings ▪ Pneumonia committee (11/22/10 to 2/16/11) 8. Individual PNMPs for individuals reviewed above 9. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 10. Tools used to assess PNM status and needs 11. A list of PNM assessments and updates completed in the last two (2) quarters 12. Tools used to monitor implementation of PNM procedures and plans 13. A list of individuals for whom PNM monitoring tools were completed in the last quarter 14. Tools utilized for validation of PNM monitoring 15. 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 16. Nutritional management plan template and any instructions for use of template 17. Dining Plan template 18. Morning meeting minutes: Three Rivers (1/12/11 and 3/9/11); Neches (11/10/10, 1/14/11, 1/19/11, 1/29/11, and 3/9/11); Four rivers (1/14/11, 1/19/11, and 3/9/11) 19. Lists of individuals: o On modified diets/thickened liquids; o Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; o With BMI equal to or greater than 30; o With BMI equal to or less than 20; o Since October 1, 2010, who have had unplanned weight loss of 10% or greater over six (6) months; o During the past 12 months, have had a choking incident; o During the past 12 months, have had a pneumonia incident; o During the past 12 months, have had skin breakdown;

	o During the past 12 months, have had a fall; o During the past 12 months, have had a fecal impaction; o 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.); o With poor oral hygiene; and o Who receive nutrition through non-oral methods 20. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation during the past year 21. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 22. Tools and checklists used to provide competency-based training addressing: 23. Foundational skills in PNM; and 24. 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 **People Interviewed:** 1. PNM Team (David Taylor OTR, Jean Cuevo PT, Sally Martinez RN, and Brandy Rabe SLP) 2. DCPS (Three-Trinity, Three-Leon, Three-San Antonio, Two-Neches) **Meetings Attended/Observations:** 1. Meals on Trinity, Leon, Neches and San Antonio 2. Transition times (Leon, San Antonio) 3. Medical Nutrition Therapy Meeting 5/2/11 4. Pneumonia Meeting 5/3/11 5. PSP for Individual #477 6. At Risk Team Meetings for Individuals #363 and #385
	Facility Self-Assessment: For Provision P.1, the Facility stated they are not in compliance with this provision. RSSLC stated that individuals are evaluated upon admission and within 30 days of need identification. Also, evaluations have started to include information on oral care and medication administration and beginning by May 2011, evaluations will also include head of bed elevation. While the assessments were improved from the previous onsite review, there continued to be some issues related to these. For example: • There was a significant amount of health data reported in the assessments, but no evidence of a comparative analysis of health and functional status from the previous year. • There was little to no discussion of potential for skill acquisition across a variety of areas including eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • There was no analysis of findings that was based on the data reported compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. • Although most areas that should be addressed in these evaluations were addressed, missing from

	the assessment 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 Provision P.2, the Facility stated they are not in compliance with this provision. RSSLC stated Supported Visions training was implemented that included expansion and increased participation in the Personal Support Team (PST) process. There was no evidence that individuals participating in the sensorimotor programs were followed or reviewed by the therapist except during the annual update and even then, there was little to no information provided regarding progress with the program. For Provision P.3, the Facility stated they are not in compliance with this provision. RSSLC stated that staff was trained in the form of return demonstration for each change to an individual's PNMP. Per POI, all staff had been provided with competency based PNM training and all staff received annual PNM refresher training. In addition to the PNM training, staff also receive annual refreshers regarding Ambulation, and Lifting/Transfers. The claim of the POI was unable to be verified due to RSSLC not having a clear system to track staff trainings and therefore identify who had and who had not received the training. For Provision P.4, the Facility stated they are not in compliance with this provision. RSSLC stated that a comprehensive monitoring tool was developed that will monitor multiple aspects of PNM concerns during one monitoring event. A system has been put into place that involves PNMP coordinators as well as all therapists to monitor individuals during all parts of their daily activities. The self-assessment of noncompliance in all sections was consistent with the monitoring team's assessment of noncompliance with this provision.
	Summary of Monitor's Assessment: **Provision P.1:** This provision was determined to be not in compliance. RSSLC reported that they had full staffing with regards to Occupational and Physical Therapy. In general, an initial OT/PT Comprehensive Evaluation was completed for each individual upon admission. While the assessments were improved from the previous onsite review, there continued to be some issues related to these. For example: • There was a significant amount of health data reported in the assessments, but no evidence of a comparative analysis of health and functional status from the previous year. • There was little to no discussion in evaluations of potential for skill acquisition across a variety of areas including eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • There was no analysis of findings that was based on the data reported compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports.

	• Although most areas that should be addressed in these evaluations were addressed, missing from the assessment 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. **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. There was no evidence that individuals participating in the sensorimotor programs were followed or reviewed by the therapist except during the annual update and even then, there was little to no information provided regarding progress with the program. **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. There was also no system for acquiring data for analysis and review. Overall, little progress was noted in all provisions; however, per report of the acting Director of Habilitation Services, a program is about to be implemented that will focus on improving head of bed assessment and will include pressure mapping and assessment of tolerance in addition to assessing ability to mitigate risks associated with aspiration.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical	RSSLC had six Occupational Therapists, six Physical Therapists, three Certified Occupational Therapy Assistants (COTAs) and two Physical Therapy Assistants (PTAs). There was an opening for the Director of Habilitation Services. An OT and PT both had full caseloads and served as acting co-directors of Habitation Services. Per interview with the co-directors, RSSLC planned to have a dedicated PNMT, which would remove both an OT and PT from having active caseloads. Based on a review of CVs for each therapy clinician, the appropriate qualifications were found for the co-directors of Habilitation Services, five OTs, five PTs, three COTAs, and two PTAs. All licenses were current.	Noncompliance

#	Provision	Assessment of Status	Compliance
	therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	All individuals received an OT/PT assessment on an annual basis if they had required supports or services during the previous year. These were identified as either an OT/PT Comprehensive Assessment or Habilitation Therapies OT/PT Update. The format of these was nearly identical and it was unclear why one was considered an update while another was considered to be a comprehensive evaluation. A plan was in place to provide a comprehensive assessment every three years with an update in the interim years for those who received supports and services. The OT/PT Evaluation template included the following sections: • General Information; • Behavioral Consideration; • Motor/Functional Evaluation/PNMP: • Physical Management Information; • Reflexive/Orthopedic Abnormalities; • Range of Motion; • Muscle Tone/Strength; • Handling/Transferring; • Mobility/Locomotion; • Respiratory Function; • Sensorimotor Function; • Fine Motor Function; and • Activities of Daily Living; • Oral Motor/Eating Ability/Nutritional Status: • Nutritional Status; • Oral/Developmental Abnormalities; • Oral Control; • Diet Texture/Method of Feeding; • Behavioral Considerations; and • Feeding Techniques; • Assistive/Supportive Devices; • Summary/Recommendations; • Reassessment schedule In general, an initial OT/PT Comprehensive Evaluation was completed for each individual upon admission. While the assessments were improved from the previous onsite review, there continued to be some issues related to these. For example: • There was a significant amount of health data reported in the assessments, but no evidence of a comparative analysis of health and functional status from the previous year.	

#	Provision	Assessment of Status	Compliance
		• There was little to no discussion of potential for skill acquisition across a variety of areas including eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • There was no analysis of findings that was based on the data reported compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. • Missing from the assessment 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. Examples include: • OT/PT Update for Individual #199 stated that supervision was needed and that decreased stride length was noted. There was no information regarding if this observation was a change in status or how it differed from previous updates. • OT/PT update for Individual #597 stated that a gait belt was needed for ambulation. The update also stated that the individual participated in a walking program but did not state if there had been any progress. • OT/PT update for Individual #426 stated there was inconsistent chewing but did not provide the functional result of the deficiency. The OT and PT clinicians conducted their annual assessments together, though issue-specific consults were generally discipline-specific. They appeared to work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and other supports and services as indicated. Based on record review, 26 of the 26 OT/PT Evaluation and/or Updates (100%) included signatures and date by the OT and PT. Per interview with the Acting Director of Habilitation Services, the SLP will begin to participate in the assessments to address communication and oral motor and dysphagia issues. Per interview with PTs, there was not a clear reliable system in place to ensure that they were notified of falls or wheelchair issues in a consistent and timely manner. Based on record review of 26 individuals of whom ten had experienced a change in health or physical status, 10 of 10 individuals (100%) had not received a comprehensive OT/PT assessment within 30 days or sooner as indicated to address health and/or safety. Examples include:	

#	Provision	Assessment of Status	Compliance
		• Individual #6 was diagnosed with aspiration pneumonia on 7/5/10. There was no PST or PNMT response to the incident. • Individual #16 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 • Per review of the morning meeting minutes, Individuals #17, #95, #487, and #677 all had multiple falls but there was no evidence of comprehensive review to determine root cause of falls and methods to mitigate risk. The Monitoring Team observed a morning meeting at Four Rivers where a fall was recorded but there was no evidence of review or discussion on methods to mitigate risk.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Plans were generally limited to the PNMP that was reviewed at the time of the annual PSP. All of the plans submitted were current within the previous 12 months and many had been updated since the PSP. Changes were identified by a symbol on the plan to alert staff to a change from the previous version. The number of individuals receiving direct and/or indirect OT and/or PT services froma therapist was 18 individuals (4.6% of current census). 92 individuals (23% of current census) received some type of sensorimotor program. The sensorimotor programs included activities focused on walking, range of motion, conditioning, balance, weight bearing, and balance and was provided by DCPs, PNMP coordinators and a PT tech. There was no evidence that individuals participating in the sensorimotor programs were followed or reviewed by the therapist except during the annual update and even then, there was little to no information provided regarding progress with the program. Individuals not receiving direct services were not consistently reviewed by OT/PT should there be a change in status. Individuals who were referred to sensorimotor programs (care provided by PNMP Coordinators, DCPS, and PT tech) did not have their data collected in a manner that shows decline or progress. Data are collected either by sign off or by simply stating that the activity occurred. In the case that an individual received direct therapy, daily progress notes were not consistently written nor were monthly summaries clearly identifying the degree of progress obtained from treatment. For examples: • Individual #683 was being seen for direct OT/PT services but there was no evidence of weekly or monthly notes. Additionally, in zero of four records reviewed of individuals receiving direct OT/PT services (0%), there was a clear assessment present in the record prior to beginning treatment. For example:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #601 received treatment for conditioning but there was no assessment conducted prior to beginning care that clearly described the rationale for such interventions. Per review of the annual update, it stated that treatment was not needed. • Individual #693 received treatment for ambulation but there was no full assessment that clearly identified how level of functioning had declined. When individuals' status changed, there was not consistent review and/or modification to plans. This is discussed above, and examples provided with regard to Provision O.4 of the Settlement Agreement	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	Staff did not implement recommendations identified by OT/PT. Though equipment generally was available, implementation of OT/PT recommendations by staff was not consistently performed as intended per the PNMP or per generally accepted practice. Some examples in addition to the ones listed for Provision P.1 included the following: 4. Individual #215 was observed slid down in bed and collapsed forward and to his right, while the plan called for him to be in a neutral position and elevated to 30 degrees. 5. Individual #503 did not have a foot box under the feet during the meal as outlined in the dining plan and PNMP. In general, however, it appeared from observations that there were improvements in staff attention to thedetails of proper positioning and compliance with the PNMPs compared to what wasobserved during the previous onsite review. Transfers observed were completedappropriately. Per interview with three DCPs on Trinity, three DCPs on Leon, three DCPs on San Antonio and two DCPs on Neches, most staff understood various techniques designed to ensure safe eating and positioning but did not consistently understand the rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP. • In nine of 11 interviews (81%) with staff, staff could identify the location of PNMP and/or mealtime plan • In six of 11 interviews (54%) with staff, staff could describe individual-specific PNMP strategies • In four of 11 interviews (36%) with staff, staff could explain the rationale or reasoning behind the strategies that were implemented • In six of 11 interviews (54%) with staff, staff could describe the schedule for implementation of PNMP strategies • In six of 11 interviews (54%) with staff , staff stated they had received	Noncompliance

#	Provision	Assessment of Status	Compliance
		individual-specific training for PNMP strategies • In three of 11 interviews (27%) with staff, staff were able to explain the importance of the aspiration trigger data sheet. Examples of direct support professionals who were not able to describe the following PNMP indicators: • DCPs on San Antonio and Trinity stated that strategies to mitigate the risk associated with aspiration were limited to mealtimes. • DCP on Trinity was not able to state why alternating liquids and solids decreased the risk of choking • DCP on San Antonio stated that positioning was important to reflux and reflux only. Per report of the Acting Director of Habilitation Services, a process will soon be in place that will focus on improved individualized competency based training. "Competency-based binders" will be placed on the dorms; The competency based binders are binders that will include all individualized methods that will be trained to staff prior to working with the person. These methods include mealtime strategies as well as positioning and transfer instructions. PNMP coordinators will utilize these binders to provide training on positioning, adaptive equipment and mealtime strategies.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	A system does not exist to routinely evaluate outside of the annual update fit, availability, function, and condition of all adaptive equipment/assistive technology. Monitoring forms had been modified to focus on all areas of the individual's day but there was not a formal system that clearly defined the areas that would be monitored, the frequency in which it would be monitored, and staff responsible for conducting monitors. Additionally, there was not a data system that allowed for the tracking and analysis of acquired data from the completion of the monitoring forms. Person specific monitoring was not consistently conducted that focused on plan effectiveness and how the plan addresses the identified needs. Since the majority of monitoring was conducted by Physical and nutritional management plan coordinators (PNMPCs) and therapy technicians, it was primarily limited to availability and condition of equipment, rather than efficacy of the interventions in the PNMPs. Additionally, the frequency of monitoring was not driven by level of risk. There were no policies or guidelines to address the monitoring process. Per interview with Acting Director Of Habilitation Services, procedures were communicated to staff	Noncompliance

#	Provision	Assessment of Status	Compliance
		via in-service training and validation of PNMPCs was completed by licensed clinicians. Validation was accomplished by both the clinician and the PNMPC monitoring an individual then comparing notes regarding accuracy. Differences in findings were discussed with the PNMPCs but there was no formal process and no method for tracking the finding of the monitoring forms or the results from the validation checks. For individuals at increased risk, staff responsible for positioning and transferring them did not consistently receive training on positioning plans prior to working with the individuals. This included pulled and relief staff. There was no system toassure that those who were most at risk were assisted only by competent and well-traineddirect support staff but, as mentioned in Provision P.3, this was an area that would be addressed by the implementation of the competency based binders.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The frequency of PNMP monitoring needs to be driven by risk level; those at highest risk must be monitored with sufficient frequency to ensure adequacy and efficacy of the supports provided as well as the accuracy of staff implementation of these supports. All PNM-related risk issues must be considered when assigning needed frequency of PNMP and mealtime monitoring.
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 processes of analyzing monitoring reports and of 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.
8. Involve the Speech Language Pathologist during the assessment process regarding oral motor and swallowing function to improve the measurability of findings thus allowing for comparative analysis from assessment to assessment.
9. Risk indicators should be considered in a more integrated manner throughoutthe report. The analysis of findings should cross all systems or clinical areas and should formulate the foundation or rationale for why specificaspects of the PNMP as well as other supports, service and interventions were indicated. These should then be listed as recommendations.
10. Thepotential for skill acquisition sections should not be used predominately to justify barriers to learning new skills but rather interventions andsupports that could teach new skills and mitigate barriers to learning. Skill acquisition should be looked at as an opportunity to improve one's independence and not as a method to justify the level of support. Focus should be moving past the barrier and improving ones level of functioning and interaction with the environment.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Plan of Improvement, dated 4/18/2011 2. Richmond State Supported Living Center Dental Clinic Policy and Procedure: Emergency Procedure, undated 3. Integrated progress notes for Individuals #349, and #399 4. Dental progress notes for Individuals #349, and #399 5. Report titled "missed dental appointments for past six months", dated 5/5/11 (data provided was from January 2011 – May 5, 2011) 6. List of individuals who require TIVA 7. PSPs and Addendum to PSPs for Individuals #349, #399, individuals #321, #134, #530, #625, #284, #765, #477, #655, #375, #308, #161, #162, #361, #723, #728 8. Dental Clinic Policy and Procedure: Brushing Program, undated 9. Behavior Progression Form **People Interviewed:** 1. Carol Heath, DDS, Dental Director **Meetings Attended/Observations:** 1. Observation of individuals at Trinity living area for oral health care issues 2. Throughout its review of the Facility, the Monitoring Team observed individuals entering and exiting the Dental Office and limited observation of services offered by the Dental Office. 3. At Risk Team Meetings for Individuals #363 and #385
	Facility Self-Assessment: The Facility reported to the Monitoring Team that it remains out of compliance with Provision Q.1, of the Settlement Agreement. Working towards compliance, Dental Services has hired an additional Dentist and has developed a relationship with a local out-patient surgical center and oral surgeon who will provide services to Individuals who require general anesthesia. The Facility has also developed a new QA process to better monitor outcomes related to dental services. The Facility reported that it remains non-compliant with Provision Q.2, of the Settlement Agreement. Working towards compliance, the Facility had begun developing an Oral Hygiene Care Plan for each individual seen in the Dental Clinical. A description of the individual's oral condition and dental clinic recommendations is expected to be documented. This process is expected to be completed by 4/30/11. The Facility also developed a Behavior Progression form to continue the process of implementing

	strategies to improve compliance with dental care. This process is expected to inform behavioral services clinicians and the PST about the individual's behavior issues.
	Summary of Monitor's Assessment: The Monitoring Team was enabled a quality meeting with the Facility's Dental Director, and was able to observe some level of practice at the Dental Office. The Dental Office was equipped with relatively modern technology and appeared to be in order and clean. Despite possible staffing and resource limitations, the Dental office was well managed. The Dental Director demonstrated a level of professionalism and commitment to individuals served by the Facility that was commendable. Any adverse issue reported in Provision Q.1 and Q.2, should not reflect negatively on dental personnel, but indicates system issues and resource limitations that must be addressed. The Monitoring Team concurred with the Facility's self-assessment and determined that the Facility was not compliant with Provision Q.1, of the Settlement Agreement. Enhancements that include improving oral hygiene and suction tooth brushing at the living area, enhancing the dental record system and scheduling of dental services, increasing the amount of TIVA offered to Individuals, implementing general anesthesia, and developing comprehensive policies for TIVA, general anesthesia and oral sedation, must be accomplished before further consideration for compliance can be entertained for Provision Q.1. Before the Monitoring Team can consider substantial compliance for Provision Q.2, of the Settlement Agreement, the Facility must enhance its ability to incorporated oral health and hygiene issues in the PST process, establish a meaningful database for sedation and behavior management, enhance its ability to communicate and schedule dental services, ensure that quality oral hygiene services are provided at the living areas, and that the use of suction tooth brushes is offered to all Individuals who can benefit from them. For these reasons, the Monitoring Team determined that the Facility was non-compliant with Provision Q.2, of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for	The Facility reported to the Monitoring Team that it remained out of compliance with Provision Q.1, of the Settlement Agreement. To assess their status, and possible compliance the Monitoring Team evaluated the Facility's provision of emergency and routine dental services at the Facility. Specific to Emergency Dental Services, the policy provided to the Monitoring Team did not reflect the Facility's process, as described to the Monitoring Team. The process, as outlined by the Dental Director, ensures that all Individuals who experience a dental emergency during regular business hours are promptly triaged by the Facility's dentist. During after hours, Individuals are expected to be immediately triaged by the Facility's on-call physician, who is to assess the condition, and prescribe appropriate medical care. In the event that prompt dental service was necessary, the dentist is paged and will triage the case. In the event that the dentist is not available, the hygienist is paged and	Noncompliance

#	Provision	Assessment of Status	Compliance
	persons with developmental disabilities shall satisfy these standards.	will assess the Individual and refer the individual to a local community dentist, who has agreed to treat dental emergencies. The Dental Office maintains a database for dental emergencies, and during the past six months, two cases were reported as dental emergencies. Following review of dental progress notes, the Monitoring Team determined that appropriate dental services were provided in triaging dental emergencies. While assessing the delivery of routine dental services at the Facility, the Monitoring Team identified that since the Facility began tracking missed dental appointments in January, 2011, 350 Individuals missed their scheduled dental appointment and required the appointment to be rescheduled. Of the 350 missed appointments, 108 were secondary to actual no-shows. A no-show generally occurs when after the dental office notifies the living area in advance, and re-notifies the living area on the day of the appointment, but the individual is not taken to the dental office. Common reasons given for a no-show appointment was because the living area day staff forgot to inform the afternoon staff of the appointment, and because of limited staffing issues at the living area. Other system issues that result in missed appointments include understaffing of the dental office with clerical support and an antiquated mechanism to maintain dental records and scheduling. The magnitude of missed dental appointments is a rate limiting factor for compliance with provision Q.1, of the Settlement Agreement. The Monitoring Team would like to comment on the excellent quality of the Facility's missed appointment database. The database enables meaningful analysis of missed appointments. At the time of this review, the Facility did support and implement the dental guidelines promulgated by the American Dental Associations for persons with developmental disabilities. Importantly, the Dental Director had attended continuing education sessions on dental services for people with developmental disabilities. Another rate limiting issue for the Facility was the inability to provide timely dental treatment for individuals who require i.v sedation (TIVA). At the time of this review, the Facility contracted with an out-side anesthesiology firm to provide TIVA for the 150 individuals who were identified as requiring i.v.sedation for dental treatment. TIVA services were only provided twice per month and resulted in a backlog of six months duration (absolute count of individuals was not available to the Monitoring Team). The earliest someone could be seen under i.v.sedation for a dental emergency would be six weeks. There had been adverse outcomes noted, secondary to limited TIVA services at the Facility. The Facility had yet to fully implement a suction toothbrush program at the Facility. Only one living area was being piloted for suction tooth brushing and the Dental Director	

#	Provision	Assessment of Status	Compliance
		shared her concerns with possible funding limitations that may hinder further implementation. Importantly, oral hygiene at the living area must be significantly enhanced. The Monitoring Team observed Individuals on Trinity living area to have poor oral hygiene. During subsequent reviews, the Monitoring Team will further evaluate oral hygiene efforts at all living areas. Unless consistent and high quality oral hygiene is maintained at the living area, oral health care needs will not be met and the Facility will not gain compliance with provision Q.1, of the Settlement Agreements. The issue of delivery of oral hygiene support at the living area was discussed with the Dental Director, who concurred fully with the Monitoring Team's assessment and concerns. The Monitoring Team was informed that approximately 22 individuals were deficient with dental treatment because of their need for general anesthesia. Because of local resource issues, the Facility was unable to arrange general anesthesia for this population. More recently, the Facility was able to establish a contract with a local out-patient surgical center and oral surgeon, who will treat individuals from the Facility. This process had not yet been implemented but was schedule to start in May, 2011. The Facility does not have a policy in place for general anesthesia. The Monitoring Team concurred with the Facility's self assessment and determined that the Facility was not compliant with Provision Q.1, of the Settlement Agreement. Enhancements that include improving oral hygiene and suction toothbrushing at the living area, enhancing the dental record system and scheduling of dental services, increasing the amount of TIVA offered to Individuals, implementing general anesthesia, and developing comprehensive policies for TIVA, general anesthesia and oral sedation, must be accomplished before further consideration for compliance can be entertained for Provision Q.1.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions;	The Monitoring Team reviewed the PSPs and addendum to PSPs of Individuals #349, #399, individuals #321, #134, #530, #625, #284, #765, #477, #655, #375, #308, #161, #162, #361, #723, #728. The Monitoring Team noted that in all cases, oral health and oral hygiene issues were not adequately reflected, and did not provide necessary insight into the oral, and dental needs of the Individuals served. It was evident to the Monitoring Team that an effective mechanism of incorporating oral care needs into the team process is seriously lacking at the Facility, and is a rate limiting factor for compliance with Provision Q.2, of the Settlement Agreement. The Monitoring Team recognized that given staff limitations, the Dentist will not be able to attend all PST meetings; however, the Facility can, by enhancing documentation of oral and dental health care and hygiene needs, and perhaps by utilizing a electronic dental record system, ensure that meaningful and relevant dental issues are well communicated to the PST. Dentists and Hygienists can attend specific PST meeting, when necessary. The PST can better educate members	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	on oral health care and hygiene issues. The issue of TIVA and general anesthesia has been covered in Provision Q.1, and assessment of the Facility's use of oral sedation is covered in Provision J, of the Settlement Agreement. Dental desensitization issues will also be covered in Provision J, of the Settlement Agreement. The Monitoring Team was made aware of a "brushing program" that was developed and implemented by the Dental Services for the purposes of helping to desensitizeindividuals to dental treatment and also to help enhance oral hygiene for individuals who experience behavior challenges during the application of oral hygiene. The brushing program was administered by the Facility Hygienists on Friday mornings, at the dental office, for 44 individuals, and at the living area for 27 Individuals. A total of 77 Individuals were provided assistance through the brushing program. Outcome data had not been captured; however, anecdotal review by the Dental Director indicated that benefit had been achieved through this program. The Monitoring Team suggested collecting outcome data to demonstrate efficacy and to incorporate the program along with the Psychology departments attempt at desensitization. The Monitoring Team is acutely aware of the risks and benefits, and expected outcomes offered by dental desensitization programs, and when developing or enhancing a dental desensitization program, safety is paramount; hence, the potential for drill accidents and other potential injuries to the Individual and staff must be of primary concern. For this reason, additional personnel support should be considered when assisting individuals with expected behavior challenges. The Facility had established a high quality, efficient database system to track missed appointments, which is described in Q.1, of this report. However, a similar process for tracking the use of all forms of sedation and behavior management had yet to be developed. The Facility has begun implementing a "Behavior Progression Form," which, when completed, will describe the individual's behavior challenges and needs. The completed form will be provided to behaviorists and to the PST, so they will better understand the behavior needs of individuals served. Before the Monitoring Team can consider substantial compliance for Provision Q.2, of the Settlement Agreement, the Facility must enhance its ability to incorporate oral health and hygiene issues in the PST process, establish a meaningful database for sedation and behavior management, enhance its ability to communicate and schedule dental services, ensure that quality oral hygiene services are provided at the living areas, and that the use of suction toothbrushes is offered to all individuals who can benefit from them. For these reasons, the Monitoring Team determined that the Facility was non-compliant with	

#	Provision	Assessment of Status	Compliance
		Provision Q.2, of the Settlement Agreement.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Update the policy for emergency dental services to better reflect the Facility's functional procedures for managing dental emergencies.
2. A modern mechanism must be instituted to maintain dental records and the dental schedule, at the Facility.
3. The Facility must reduce the rate of missed dental appointments
4. The Facility should review staffing needs at the Dental Office.
5. It is essential that the Facility decrease the waiting list for dental services for people who require i.v.sedation. The Facility must increase TIVA services to accommodate the needs of individuals served by the Facility.
6. The Facility must immediately ensure that all individuals at the Facility are provided with adequate and appropriate oral hygiene support, as determined by the Dentist, and Dental Hygienist
7. Develop local, comprehensive policies that accurately reflect the Facility's process for the use of general anesthesia, TIVA and oral sedation
8. Immediately enhance the PST process and PSP reports with regards to oral health care and issues, so PSPs adequately reflect the needs of the Individuals
9. The Facility must develop a robust database or other process that comprehensively tracks all forms of sedation (oral, TIVA, general), and behavior management, that is required when providing dental services. In addition to identifying who requires such support, and the type of support provided, appropriate health care indicators, such as outcomes and tolerance to sedation and behavior management, should be collected and analyzed.

The following are offered as additional suggestions to the facility:
1. Consider two person support for all individuals who are known or expected to have behavior challenges when providing dental services for all dental evaluations and treatments.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Plan of Improvement, (POI) 04/18/2011 2. Record reviews of Individuals: #12, #43, #48, #56, #71, #110, #252, #308, #399, #452, #525, #559, #771, and #783 3. Policies, procedures and/or other documents addressing the provision of speech and/or communication services and supports (RSSLC policy K.6- Communication Services) 4. A list of people with Alternative and Augmentative Communication (AAC) devices 5. AAC evaluation and Speech Language assessment template. 6. Five (5) most current AAC and SLP assessments conducted by each therapist, and corresponding PSPs provided in response to the document request 7. Monitoring tools template for ACC and SLP programs 8. Communication dictionaries for individuals identified as having decreased communication. 9. AAC-related spreadsheets. 10. Speech Therapy Database 11. Speech Master List 12. List of individuals receiving direct speech services, and focus of intervention. **People Interviewed:** 1. Brandy Rabe SLP, Rochelle Kelly SLP, and Dora Hwang SLP 2. DCPs (Three-Trinity, Three-Leon, Three-San Antonio, Two-Neches) **Meetings Attended/Observations:** 1. Meals on Trinity, Leon, Neches and San Antonio 2. Transition times (Leon, San Antonio, Neches, Trinity) 3. Medical Nutrition Therapy Meeting 5/2/11 4. Pneumonia Meeting 5/3/11 5. PSP for Individual #477 6. At Risk Team Meeting for Individuals #363 and #385
	Facility Self-Assessment: For Provision R.1, the Facility stated they are not in compliance with this provision. RSSLC stated that five SLPS resigned from the facility between 2/1/11 to 4/1/11. At the time of the review, RSSLC had three full time SLPs and three vacancies. For Provision R.2, the Facility stated they are not in compliance with this provision. RSSLC stated that a new screening and evaluation process had been implemented that more fully identified an individual's strengths and weaknesses. The Monitoring Team determined this had not been implemented at the time of the compliance visit. For Provision R.3, the Facility stated they are not in compliance with this provision. RSSLC stated a system was initiated to identify individuals who would benefit from high tech devices.

	AAC devices were not consistently available, utilized, portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs. For Provision R.4, the Facility stated they are not in compliance with this provision. RSSLC stated thatthe QAstaff trained the SLPs on the Section R monitoring tool and guidelines. The self-assessment of noncompliance in all sections was consistent with the monitoring team's assessment of noncompliance with this provision.
	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 128. With the current ratio, RSSLC will find it extremely difficult to make substantial improvements. **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 still had not been implemented at the time of this review. **Provision R.3:** This provision was determined to be not in compliance. AAC devices were not consistently available, utilized, 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. Additionally, all monitoring processes were informal and did not provide clear information regarding detail of monitoring practices as well as frequency in which they should be conducted. Overall, there has been little to no progress in this area. RSSLC has had substantial staffing changes that have resulted in staffing ratios that are hindering the extent to which progress may be accomplished. As stated previously, RSSLC only has three SLPs. One SLP was to focus on swallowing with the other two left to focus on Language and Augmentative Communication. This means that one SLP will need to cover 384 individuals regarding their swallowing and risk of aspiration while the other two SLPs will carry an average caseload of 192. With the current caseload, it will be difficult to make any substantial progress in this area.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of	The Facility did not provide an adequate number of speech language pathologists or	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	other professionals (i.e., AT specialists) with specialized training or experience. Training included augmentative and assistive communication. At the time of the onsite monitoring review, SLP staffing was as follows: • Rochelle Kelly MA, CCC-SLP • Dora Hwang, MA, CCC-SLP • Brandy Rabe, MA CCC-SLP All staff were full time state employees. Prior to the visit, RSSLC lost five SLPs and hired a SLP resulting in a total loss of three SLPs since the last review in October 2010. One SLP was to focus on swallowing with the other two left to focus on Language and Augmentative Communication. This means that one SLP will need to cover 384 individuals regarding their swallowing and risk of aspiration while the other two SLPs will carry an average caseload of 192. With the current caseload, it will be difficult to make any substantial progress in this area. Due to the lack of staffing, adequate and appropriate communication services were not provided for the individuals who presented with significant communication deficits at RSSLC. General tasks in which Speech Pathology is responsible: • Attendance at: o pre-admission meetings o 30 day planning conferences for all new admissions o Annual planning conferences • Conduct/write Communication Assessments • Provide direct treatment services • Maintain training data as applicable • Develop and implement augmentative and alternative communication devices • In-service and monitor use of the devices • Maintain contact with personnel regarding school age residents • Provide consultation, counseling and referral as needed • Provide new employee orientation • Modified Barium Swallow Studies (MBSS) • PNMT meetings • PSP meetings • Meal Monitoring At the time of the review, only two individuals (0.5% of the census) received direct speech treatment.	

#	Provision	Assessment of Status	Compliance
		Records were reviewed of a sample of 14 individuals; these individuals were not a random sample but were selected from a list of individuals identified as having severe language disorders and supplemented by individuals noted by the Monitoring Team.One of 14 recordsreviewed (7%) indicated individuals with identified language difficulties were 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: • Per Speech Therapy Database, Individuals #12 and #252 had picture boards but there was no evidence of assessment of the device or development of a program to increase usage of the device. Per report by the SLPs, there were at least 180 individuals who were identified as nonverbal or nonfunctional communicators who would be considered to have significant communication limitations. It was of concern that only 0.5% of the individuals living at RSSLC received direct communication services. Of the individuals included in the sample for review, there were only two individuals who had been recommended for direct supports and services and only one who had actually received them per the documentation submitted.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	Per review of the SLP master list, a priority list had been developed for AAC evaluation; however due to staffing issues the schedule had been abandoned. 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 support plans (PBSPs) and aggressive behaviors • Priority 2-Nonverbal individuals with PBS without aggressive behaviors • Priority 3-Nonverbal individuals without PBS • Priority 4-Individuals with severely distorted speech • Priority 5-other All individuals identified with severe expressive/receptive language deficits were not identified as being in need of AAC.One of the 14 records reviewed (7%) indicated that individuals identified with severeexpressive/receptive language deficits had AAC investigated, assessed, and if identified as beingin need of AAC, were provided ongoing support by an SLP to support the facilitation offunctional communication. Examples of	Noncompliance

#	Provision	Assessment of Status	Compliance
		concerns are provided with regard to Provision R.1 of the Settlement Agreement. For persons receiving behavioral supports or interventions, the Facility did not have a screening and assessment designed to identify who would benefit from AAC. For example: • Individuals #252, #452, and #771 all were listed as having severe language deficits and aggressive behaviors (Priority 1) connected to the lack of communication but were not provided with devices to assist the reduction of undesired behavior. Additionally, there was no integration or evidence of collaboration between the SLP and the Psychologists regarding how communication strategies or devices may be helpful in reducing undesirable behaviors or evidence of assessment of undesirable behaviors in an effort to identify communicative intent. In zero of the 14 records reviewed (0%), 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. Although there were sections in the assessment that addressed verbal and nonverbal skills; the information contained in those sections was vague and did not provide useful information that would aid in the development of skills. For example: • Individual #399's speech assessment stated communication occurred through some words and phrases but did not provide information regarding the words or phrases. • Individual #43's speech assessment stated the individual could name some presented pictures but did not provide information regarding how this translated into functional daily communication. • Individual #783's speech assessment stated that gestures were used but, again, did not provide additional information regarding the gestures. Goals written by the Speech Pathologist (SLP) were not consistently followed and data acquired regarding the goal were not analyzed by the SLP. Although the goals 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. Per report of the SLPs, Communication dictionaries were developed with input from the	

#	Provision	Assessment of Status	Compliance
		team. These dictionariesare 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, Neches and San Antonio indicated that two of 11 staff (18%) were knowledgeable of these dictionaries or its contents. Per review of the PSPs, there was not evidence that that there was active discussion regarding the dictionary as the PSP simply stated that the dictionary was reviewed.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	Rationales and descriptions of interventions regarding use and benefit from AAC were not clearly integrated into the PSP. The PSPs offered very limited descriptions of how an individual communicated with others**.** In most cases only recommendations from the communication assessment were identified rather than descriptions of the individual's abilities or potentials. Strategies that staff could use to communicate were also very limited or non-existent. For example: • Individual #783's PSP stated gestures are used but provided no information regarding strategies to improve interaction or the catalog of gestures. 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 may have been listed but these strategies were not consistently integrated into Action Plans or activities of daily living. Lack of integration results in a lack of generalization of objectives. Zero of the 14 records reviewed (0%) had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated: • Individuals #12 and #56 had picture boards but the use of the picture boards was not formalized into a communication goal or integrated into other training directives/plans. Zero of four observations (0%) had communication strategies integrated into the daily schedule. For example, common area devices in the dining rooms and hallways were not observed to be used on San Antonio, Leon, Neches or Trinity. AAC devices were not portable and functional in a variety of settings.None of the 14 PNMPs reviewed (0%) reinforced the use of AAC devices that wereportable and functional in a variety of settings (i.e., mealtime, work, leisure, residence, and community outings).	Noncompliance

#	Provision	Assessment of Status	Compliance
		Zero of 14 records reviewed (0%) clearly indicated how the individual communication goals or recommendations were functional and meaningful to the individual and how they improved his/her daily living. DCPs interviewed were not knowledgeable of the communication programs as evidenced by: • In two of 11 interviews (18%) with staff, staff could describe general communication strategies. • In three of 11 interviews (27%)with staff, staff could describe the schedule for implementation of communication strategies. • In one of 11 interviews (9%)with staff, staff stated they had received individual-specific training for communication strategies. • Two of 11 interviews (18%)with staff, staff could describe general opportunities to enhance communication Training of goals and devices was conducted by the SLPs. Staff trained signed in service sheets to verify they had been trained. Training of the device was not always completed with the individual present and there was no system in place to assure missed staff were trained at a later date. A communication class was provided at new employee orientation that focused on: 1. Facial expressions 2. Basic sign language 3. Parallel talk 4. Tactile communication The new employee orientation class was trained by a CDT instructor instead of a qualified SLP. Not having a SLP conduct the class results in lack of expertise and decreases the likelihood of productive question-answer interaction. General AAC devices were not readily available or present in common areas. Four of the four homes (100%) had general AAC devices present in the Common areas; however, the presence of the devices was limited to only a few per home. Zero of the four common area AAC devices (0%) contained clear directives on how staff should utilize general AAC devices.	
R4	Commencing within six months of	A monitoring system was not in place that tracked the presence of ACC, working	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	condition of AAC, the implementation of the system, and effectiveness of the system. Monitoring was scheduled to be conducted once a month but, per interview with the SLPs, this was not consistently accomplished due to the staffing issues. Monitoring was informal and focused on the presence of the device and the working condition but did not assess whether the device was implemented or effective in assisting in the individual with improving their communicative abilities. The monitors were conducted by the speech therapists.. The communication department did have the assistance of a PNMP coordinator to help with the monitoring of the devices but since the previous visit, the PNMP coordinator had been reassigned back to PNM. As with other areas of monitoring, data acquired from the forms are not gathered and assimilated for analysis or trending. 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 ensures 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. There is no process in place that provides for validation checks to ensure consistency across monitors.Validation is accomplished by two staff (at least one being a clinician) monitoring a single individual. Once the monitoring is complete, the two staff sit down and share their observations and compare consistency of scoring.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

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. 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.
3. 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.
4. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSP.
5. 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. All training should be conducted by Speech Therapy.
6. RSSLC must aggressively recruit SLPs in order to begin to make progress with the provision. Current ratios do not allow for active participation by the SLP in PSTs as well as goal development and tracking or other activities such as staff training.
7. Audit protocols should be developed and implemented to ensure SLP Evaluations follow established guidelines as outlined in the SLPevaluation format.

8. Individuals' communication devices and strategies should be consistently integrated into their PNMPs.
9. Policies/procedures should be developed for the communication monitoring system, with performance indicators that are defined clearly. Thissystem should include, but not be limited to, a systematic and routine review of the components of the functional communication programs andequipment; staff utilization of generic AAC devices; fit, function, availability and use of AAC devices; and staff competency with regard tofunctional communication devices and programs. There should be established thresholds for staff re-training; identification, training, andvalidation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies.
10. Speech staffing must be examined to ensure that clinicians with sufficient experience in the assessment and design of communication plans forindividuals with developmental disabilities are consistently available. RSSLC may want to consider the use of Speech Assistants to assist with the implementation of communication programs (SSOs) and for staff training and monitoring.

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) 4/18/11 2. Facility Policies and Procedures 3. Minutes for the Behavior Services Peer Review Committee (PRC) meetings and Behavioral Services department meetings. Oct 2010 through March 2011 4. Preliminary materials for Competency-Based Training. 5. Annual PSP, PSP updates, Specific Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), 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 included the following individuals: #52, #68,#86, #91, #112, #146, #156, #162, #164, #174, #180, #200, #233, #252, #253, #267, #301, #372, #429, #455, #478, #508, #511, #531, #540, #552, #561, #583, #618, #630, #695, #708, and #758. **People Interviewed:** 1. William Eckenroth, PhD – Director of Behavioral Services 2. Elizabeth Ohiku,MD – Lead Psychiatrist 3. Cynthia Fannin – Director of Education and Training 4. Carol Agu – QMRP Coordinator 5. Heather Blackwell – Director of Vocational Services 6. Candice Mays, MA – Associate Psychologist 7. Emma Williams, MA – Associate Psychologist 8. Billie Dejean, MA, BCBA – Associate Psychologist 9. David Savage, Program Specialist **Meetings Attended/Observations:** 1. Active Treatment Meeting – 5/3/2011 2. Psychiatric Clinic – 5/3/2011 3. At Risk Team Meetings for Individuals #363 and #385 4. PSP for Individual #200 5/3/2011 **5.** PSP for Individual #52 5/3/2011 6. Consumer Report Observation interviews – Vocational, Forever Young and Day Program on 5/5/2011 7. Observed training, active treatment, staff interaction and meals at the following residences and programs: Angelina, Colorado, Neches, Trinity, Leon, Sabine, and San Jacinto.
	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, interviews, and record reviews were conducted on-site at RSSLC from 5/2/2011 through 5/6/2011. Record reviews continued off-site following the site visit. Based upon the information gathered, no provisions of the Settlement agreement were determined to be in substantial compliance. The most prevalent trend noted during the current site visit was the inconsistent progress achieved. It was often noted that very positive steps were taken in one area, but that related areas were substantially deficient. For example, the Facility achieved progress by developing and implementing a process for tracking and reporting the submission of assessments needed for the annual PSP. Unfortunately, despite several months of documentation, there was no trend toward more timely submission of those assessments. Without a determined effort by the Facility to coordinate and ensure the development and implementation of improvements, it is unlikely that substantial compliance with the Settlement Agreement will be achieved in the near future. The current status at RSSLC where the enthusiasm and dedication of some areas emphasized the lack of effort by other areas, will only serve to hinder the compliance process. **For Provision S.1:** The provision was determined not to be in compliance. The Facility had introduced a variety of processes to improve the quality of skill acquisition programs. At the time of the site visit, however, these efforts had produced inconsistent improvements in those programs. **For Provision S.2:** The provision was determined not to be in compliance. Although some improvement was noted in task analysis, the lack of adequate assessments of intelligence, adaptive ability, behavior, and mental illness continued to impede effective teaching. Despite several months of documentation, no trends toward improvement were noted. **For Provision S.3:** The provision was determined not to be in compliance. Skill acquisition training had improved, but the quality remained inconsistent. The implementation of training in the community was introduced, but at the time of the site visit only involved money management programs..

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with	Formal skill acquisition programs require many of the same basic components as behavior support plans: Comprehensive assessment of skills and individual resources,	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 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. During the October 2010 site visit, RSSLC had just implemented a series of efforts to improve the quality 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 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 meet the expectations established by the new training and procedures In October, due to the recent initiation of the improvement plans, a limited sample of two "best work" examples was reviewed. The review revealed the following. • A structured form of task analysis was used to assess the abilities in relation to all skill acquisition programs. • The skill acquisition programs included a formal chaining procedure including clear indication of the start of training, and consequences for successful and unsuccessful responses. • The skill acquisition programs included specific instructions for training sessions, data collection, and steps to address undesired behavior. • Data collection forms allowed for documenting the performance of the individual being trained, consequences for responses, and the level of prompt required. During the current site visit, a sample of 15 individuals was reviewed to investigate the further implementation of efforts that had begun in October 2010. For some individuals, skill acquisition programs reflected improvement. These training programs often included a task analysis, good use of discriminative stimuli, adequate opportunity for the skill to be displayed, and a thorough explanation of the documentation process. These improvements were very inconsistent, however, both across and within individual's skill acquisition programs. In many cases, instructions for program implementation were unclear. A program for money management for Individual #583	

#	Provision	Assessment of Status	Compliance
		included the following instructions that are vague and would be difficult for a DCP to implement. • Instructor places a picture of dollars amount with decimal in front of the individual and explains that he is going to learn how identify a decimal notation of money. • Instructor asks the individual to identify different amount by pointing to the dollar amount. There were also programs that lacked a clear definition of a successful response. For example, Individual #630 was involved in a vocational program that did not indicate if success consisted of completion of the vocational task, not standing too close to the instructor, or a combination of the two. • Instructor places the materials in front of him and explains the task while (demonstrating the task, using gestures, guiding his hands to complete the task). Repeat the importance of maintaining a distance when talking with others. • Instructor states initial request, “please don't get to close to me when you are talking to me. Staff provides the level of assistance as stated in “A" of fading sequence. • If the Individual performs the skill within the specified instructions, instructor provides consequence for correct response and enters initials on data sheet' under "A". Several programs also did not clearly reflect how the behavior related to the training objective or how the desired skill would be strengthened. For example, Individual #253 had a skill acquisition program to “increase ability to use money.” The methodology of the program, as written, the use of money might not be reinforced by the selected item if, for example, the individual made an error and selected the wrong item or changed choice in the interim between selecting an item and going to the vending machine but prompting prohibited selecting a different item. • Instructor shows materials to the individual and explains that she can buy some of these items from the vending machine. To buy the items she needs to have enough money or the machine will not give her the item. • Instructor explains that she would like for her to select an item that she would like to buy. Tell her the amount of money that she is receiving and take her to the vending machine. • Once in front of the vending machine instructor states the initial request and provides assistance as stated in "A" of fading sequence. In addition to the weaknesses noted above, many of the skill acquisition programs contained problems first noted during the baseline visit in April 2010.	

#	Provision	Assessment of Status	Compliance
		• 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 fewer than 10 trials per month. • Reinforcement for successful trials typically involved verbal praise. There was no indication for most individuals that verbal praise was reinforcing, nor was there documentation that assessments had been conducted to identify preferred items or activities that might be reinforcing. • 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. Recording the prompting level may be most appropriate for some skills being learned during the initial learning process. Prompts, however, involve behavior of the trainer rather than of the individual who is to learn the skill. Data collection should focus upon the behavior displayed by the learner in relation to the goals of the training program. Such data collection could focus upon a variety of skill or behavior characteristics, such as the number of successful trials, rate or frequency of the behavior, or the accuracy of the responses. Information about prompting typically has the greatest relevance in the early stages of training. Once the individual has developed a degree of independence in relation to the skill or behavior, measures of fluency, accuracy, and rate may be more useful. Decisions should be made based issues including relevance to the behavior being trained and the objective set and the individual's status of learning the skill. To be most useful for making decisions on success of the program and need for revision, 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. The Facility, however, provided samples of a new progress note template that was scheduled for implementation shortly after the current site visit. The new template included the use of data graphs. The use of this progress note will be reviewed during the next site visit. Limitations in assessments also affected whether goals of skill acquisition programs met individuals' needs. For example, There was little to no discussion in occupational and	

#	Provision	Assessment of Status	Compliance
		physical therapy evaluations of potential for skill acquisition across a variety of areas including eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. Due to limitations in assessment, the lack of adequate intervention development, and poor adherence to basic behavioral principles, there was little to indicate that skill acquisition programs possessed the sophistication necessary to make the development of skills likely. Since the October 2010 site visit, the Facility had taken substantial steps toward monitoring and strengthening active treatment. The focal point of this effort by RSSLC involved the implementation of the Consumer Report Observation system. This system combined direct observation of staff performance in residential, vocational, and programmatic areas. In addition, staff were interviewed and required to demonstrate knowledge of individuals, their programs, and Facility policy. For issues where the staff member in question was not able to demonstrate competence, brief training was provided. In a sample of 15 Consumer Report Observation assessments, 12 (80%) involved staff that were able to demonstrate success on a minimum of 80% of the 34 items assessed in this observation. While this suggested that the Consumer Report Observation was successful in enhancing staff knowledge and skills, the lack of a randomized selection process introduced the potential for a biased sample. Likewise, no data were available for the accuracy, validity, and inter-observer agreement of the assessments. Apart from concerns about validity, accuracy, and reliability, the assessments revealed areas of frequent weakness across staff. For the Consumer Report Observation system to be successful, the Facility will need to ensure that the majority of staff are able to consistently achieve a high level of success across all areas and settings. The following table provides the percentage of staff who were unsuccessful in specific areas of assessment.	

Area of Assessment	Percentage of Unsuccessful Staff
Able to describe restrictions of rights and freedoms	40%
Able to describe training programs	27%
Demonstrates appropriate use of reinforcement	27%
Interrupts or redirects undesired behavior	33%
Prompts for replacement behavior	33%

#	Provision	Assessment of Status	Compliance

Reinforcement for replacement behavior	33%
Prompts to ensure personal privacy	40%

RSSLC had also begun conducting internal audits of skill acquisition programs since the previous site visit. The audit process involved assessing compliance of the PSP and skill acquisition process with 39 items: These items were primarily derived from the tools developed by the Settlement Agreement Monitoring Teams.

Internal quality assurance audits are an integral part of successful compliance, and it was welcome that RSSLC had initiated the audit process. It was evident that the process could benefit from additional components that would enhance reliability. For example, the review tools often lacked specific definitions or criteria to be met. When staff are well-versed in applied behavior analysis and the development of formal skill acquisition programs, this can be a minimal issue. Not all staff at RSSLC, however, had that level of expertise. This made the audit process less likely to produce reliable and accurate data.

It was also noted that several of the individual audit forms that had been completed lacked sufficient detail. To be helpful in offering training to the staff on the issue in question, an audit must be as specific and detailed as possible. On many of the audit forms, descriptions of the problems were vague and incomplete.

- For items related to program instructions and teaching environment, descriptions often consisted of statements such as, "Communication skills are unclear." In order to provide staff with the necessary training, the descriptions needed to include information about how the communication skills were unclear.
- For items related to teaching opportunities in the community, forms stated that staff reported a lack of community training. The comments did not indicate whether the staff reports were correct or if other factors were involved, such as a lack of staff understanding of what constituted community training. In order to address the potential problem proactively, it was necessary to have specific information about the staff comments.

Based upon the available data, RSSLC was able to demonstrate some areas of improvement. These improvements were not, however, consistent across disciplines and settings. Additionally, substantial weaknesses noted during the baseline visit continued to exist. RSSLC must act to address these weaknesses before compliance in this Provision can be achieved. It is essential to this process that RSSLC take decisive steps to ensure that all departments and disciplines participate in steps toward compliance with the Settlement Agreement, and that those actions reflect an awareness of timeframes stipulated in the Settlement Agreement.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>S2</td><td>Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.</td><td>In regard to assessments, RSSLC displayed difficulty in ensuring that individuals received complete and comprehensive assessment as part of the PSP process and training program development. Specific deficiencies that involved psychological assessments are presented in Section K of this report. Assessment problems in addition to psychological and behavior assessment were also noted. The Facility had broadened skill assessments to include task analysis in addition to the PALS. As discussed in Section S1, however, the addition of the task analysis did not enhance the quality of skill acquisition programs. As a result, although the task analysis was a welcome addition, it had not increased the probability that skill acquisition programs were likely to strengthen skills.

Data provided by the Facility during the current site visit indicated that several departments and disciplines at RSSLC seldom submitted assessment reports at least 10 days prior to the PSP meeting as required. Furthermore, although monitoring and reporting of performance was conducted from January 2011 forward, few departments or disciplines displayed substantial improvement in complying with the requirement for timely assessments. As a result of the failure to submit assessments, the ability of the PST to review individual needs, identify areas in which each individual would benefit most from teaching, and ensure that the necessary skill acquisition programs were in place was substantially hindered.

<table><tr><td></td><td colspan="5">Percentage Received 10 Days Prior to the PSP Meeting</td></tr><tr><td>Assessment</td><td>Jan-11</td><td>Feb-11</td><td>Mar-11</td><td>Apr-11</td><td>May-11</td></tr><tr><td>Audiology</td><td>6</td><td>10</td><td>0</td><td>27</td><td>25</td></tr><tr><td>Dental</td><td>97</td><td>100</td><td>100</td><td>100</td><td>100</td></tr><tr><td>Dining Cards</td><td>67</td><td>74</td><td>81</td><td>58</td><td>25</td></tr><tr><td>Employment</td><td>18</td><td>26</td><td>15</td><td>8</td><td>0</td></tr><tr><td>Focus</td><td>58</td><td>55</td><td>56</td><td>73</td><td>25</td></tr><tr><td>Medical</td><td>64</td><td>45</td><td>52</td><td>27</td><td>50</td></tr><tr><td>Nursing</td><td>70</td><td>61</td><td>67</td><td>69</td><td>75</td></tr><tr><td>OT/PT</td><td>70</td><td>68</td><td>67</td><td>62</td><td>50</td></tr><tr><td>PALS</td><td>36</td><td>48</td><td>37</td><td>38</td><td>50</td></tr><tr><td>PFA</td><td>58</td><td>55</td><td>56</td><td>73</td><td>25</td></tr><tr><td>Pharmacy</td><td>100</td><td>97</td><td>100</td><td>100</td><td>100</td></tr><tr><td>PNMP</td><td>70</td><td>58</td><td>70</td><td>69</td><td>50</td></tr><tr><td>Psychology</td><td>64</td><td>61</td><td>44</td><td>69</td><td>25</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Restrictive Practices	61	65	59	69	50
SAMS	70	65	56	65	50
Social Development	6	3	4	12	0
Social History	94	81	89	85	75
Speech	3	3	7	0	0

Pharmacy and Dental assessments were routinely submitted as required. Other assessment reports, such as Audiology, Dining, Employment, Focus Assessment, PFA, Psychology, Social Development, and Speech, were received as required for the PSP process for only 25% or less of the individuals for whom there was an annual PSP meeting. Medical assessment, although essential to ensuring the physical well-being of the individuals living at RSSLC, were only submitted as required for half of the individuals involved in an annual PSP in the first five months of 2011. Based upon the information provided, RSSLC failed to ensure that the programmatic needs and physical health of a substantial number of people were adequately addressed.

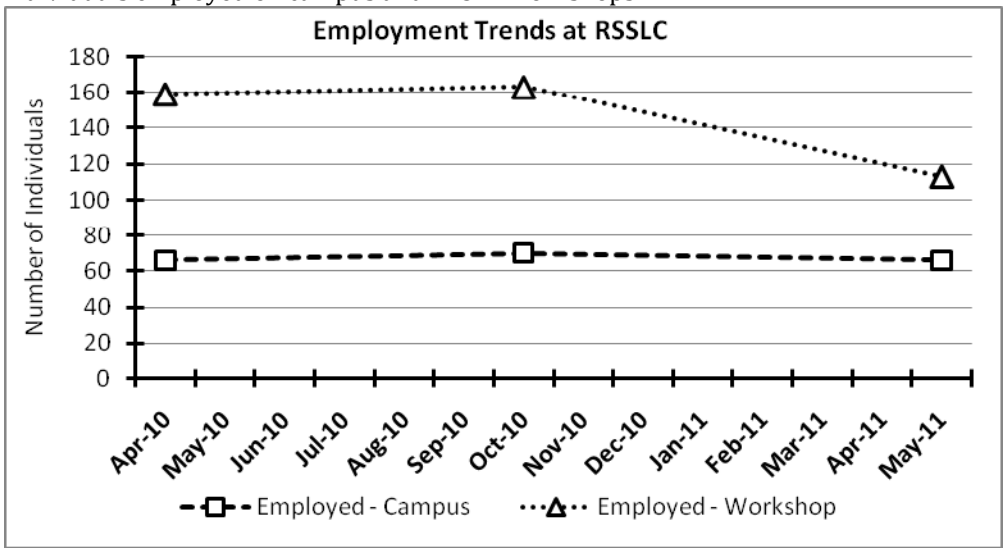
	Jan-11	Feb-11	Mar-11	Apr-11	May-11
Monthly Average	56	54	53	56	43

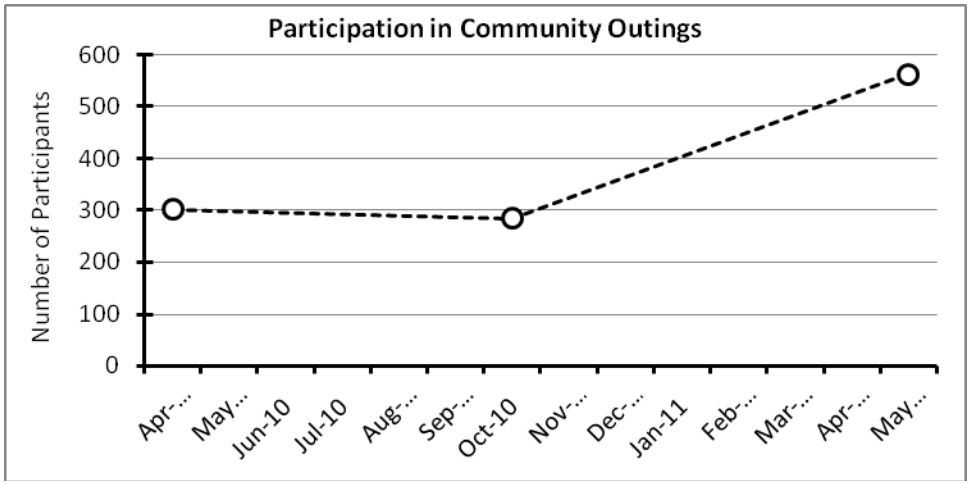
Although aware of the inadequate assessment process, RSSLC failed to take the steps necessary to ensure improvement in assessment submission practices. From January 2011 through April 2011, the average number of assessments submitted as required fluctuated within a narrow band of 53% to 56%. In May, timely assessment submissions dropped to 43%. This failure by the Facility to act prudently perpetuated a situation in which the role of the PST to ensure the delivery of skill acquisition training in the areas of living, working, and leisure, and to protect physical well-being, was substantially impaired.

Without current, comprehensive, and timely assessments, attempts to enhance the development and implementation of meaningful skill acquisition programs will be markedly impeded. RSSLC must act quickly and decisively to address these problems if compliance with this provision is to be attained within the timeframe stipulated in the Settlement Agreement.

S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to		

#	Provision	Assessment of Status	Compliance
	develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	Due to the limitations noted in Provisions K4, K5, K6, K7, and K9, as well as in Provisions S1 and S2, it was frequently not possible to determine if training programs addressed pertinent needs of the individual.Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As a result, it was probable that RSSLC did not possess a clear measure of each individual's strengths and needs, and could not develop, monitor or revise training programs with accuracy. Observations and staff interviews also revealed limitations in the application of skill acquisition programs. • In several circumstances in residences, vocational settings, and day treatment settings on 5/2, 5/3, and 5/4, staff were unable to describe the programs for which they were responsible. It was positive to note that typically these staff were able to access the program documents quickly. For programs that were to be regularly implemented, however, it was disconcerting that staff lacked personal familiarity. • During the observation of outdoor activities at the Angelina building on 5/3/2011, staff were observed to be actively engaged with the individuals in attendance. There was a small number of individuals, however, who appeared disinterested, bored, or agitated by the activities. These individuals were not observed to receive prompting or assistance from the staff. While the majority of staff actions at the activity were very positive, RSSLC should prepare staff to recognize when individuals need further supports and to offer those supports promptly. • During dinner at the Trinity residence on 5/2/2011, the following issues were noted. o Only one of seven staff (14%) was observed conversing with the individuals who were dining. o No use of positive reinforcement as part of a training program was observed. o Individual #465, who was eating rapidly, was observed to cough during the meal. Staff patted the individual on the back and then moved away. The Individual increased the rate and volume of food intake without further intervention from staff. • During dinner at the Neches residence on 5/3/2011, the following problems were noted. o Only two of five staff (40%) were observed conversing with individuals	Noncompliance

#	Provision	Assessment of Status	Compliance
		who were dining. o No use of positive reinforcement as part of a training program was observed. o Individual #677 was observed frequently to rock his head and upper body with minimal redirection from staff. When food was served, the rocking continued. Staff offered a single verbal prompt to stop. When the individual continued the behavior, no further intervention was immediately offered. Several minutes later, staff stated, "Stop" with greater volume than used previously. The rocking behavior ceased, as did the individual's eating. Staff did not clarify the prompt or offer prompts to continue eating. A minute later, both the rocking and eating resumed with no further interaction from staff.	
	(b) Include to the degree practicable training opportunities in community settings.	Since the baseline site visit in April 2010, RSSLC had not obtained employment in the community for any individuals living at the Facility. In addition to the lack of community employment, the Facility had provided progressively fewer on-campus employment opportunities. At the time of the current site visit, employment had dropped to 66 individuals employed on campus and 113 in workshops.  Although employment opportunities were decreasing, training and recreation opportunities in the community were increasing. During the six months prior to the current site visit, the monthly average of participants in community outings increased to 562.	Noncompliance

#	Provision	Assessment of Status	Compliance
		 Prior to the current site visit, there was no documentation to support that formal skill acquisition training was provided during community outings. During the current site visit, RSSLC was able to provide documentation of community-based skill acquisition training.  Although the introduction of formal skill acquisition training in the community was a	

#	Provision	Assessment of Status	Compliance
		positive step by the Facility, a variety of limitations were noted. First, as noted in Provisions K4, K5, K6, K7, and K9, as well as in Provisions S1, S2 and S3, it was not indicated that skill acquisition programs were based upon adequate assessments, reflected an adequate level of sophistication in all components, or were likely to strengthen behaviors. Second, the Facility indicated and documentation supported that the only training being provided in the community was related to money management. Based upon information obtained during the site visit, it was evident that progress had been achieved in some areas. Substantial effort will be needed, however, to ensure that all elements of this Provision meet the requirements of the Settlement agreement.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

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 take steps to improve the ability of staff to implement training programs, and refine efforts to monitor program implementation.
2. It is recommended that the Facility act to ensure that all training programs reflect an empirical, behavior-analytic approach to teaching. This includes the use of current and comprehensive assessments, 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 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.
4. 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) 4/18/11 2. RSSLCSettlement Agreement Status Update, dated May, 2011 3. RSSLC Policy F.3 Participating in Annual Personal Support Plan Meeting 9/23/10 4. RSSLC Policy F.4 Support Plan Process (Integrated Protections, Services, Treatments, and Supports)12/30/10 5. RSSLC Policy F.5 Completing Personal Support Plan Meeting Documentation 12/14/10 6. RSSLC Policy F.6 Participating In/Documenting Addendum Meetings 6/1/07 7. RSSLC Policy F.18 Participating in Personal Focus Assessment Meetings 4/20/11 8. Draft RSSLC Policy G.5 Community Exposure, undated 9. Draft DADS Policy 018: Most Integrated Setting Practices, dated variously 1/27/10 and 0/00/11 10. Since October 1, 2010, a list of individuals who have been referred for community placement by his or her PST. 11. Since October 1, 2010, a list of all individuals who have requested community placement, but have not been referred for placement. 12. Since October 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." 13. Since October 1, 2010, a list of individuals who have been discharged pursuant to an alternative discharge. 14. A current list of all alleged offenders committed to the facility following court-ordered evaluations. 15. A list of individuals who have been assessed for placement for the past 12 months, date of assessment, and resulting recommendation(s) 16. Community Placement Report, dated Monday, March 21, 2011 17. Since the last compliance visit, a list of all trainings/educational opportunities provided to individuals, families and LARs to enable them to make informed choices 18. Since October 1, 2010, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 19. Mental Retardation Authority (MRA) Community Living Options Information Process (CLOIP) Worksheets for 25 individuals with PSPs held in March 2011 20. Personal Support Plans (PSPs) for Individuals#68, #175, #197, #295, #432, #458, #579, #606, #621, #645, #687 and #747 21. Personal Focus Assessments (PFA) for Individuals #17, #39, #52, #115, #169, #179, #192, #212, #215,#259, #268, #301, #353, #363, #385, #412, #462, #471, #508, #558, #559, #561, #683, #685, #700, #712, #714, #719, and #792 22. Completed CLDPs for five Individuals #246, #285, #422, #439, and #547

	23. Partial CLDP for Individual #252 24. CLDP Attendance Signature Sheets for Individuals#246, #271, #285, #422, #439, and #547 25. Pre-Move Site Review documents for Individuals #281, #422, #467, #557, #647, #691 26. MRA Continuity of Care Pre-Move Site Review Instruments for Individuals #271, #281, #285, #422, #467, #439, #547, #557, #647, #691 27. Sample of CLDP Assessment Tracking Sheet, undated 28. DADS Obstacles Report for the State Supported Living Centers, dated 10/10 29. Completed Post Move Monitoring (PMM) checklists for Individuals #246, #271, #281, #285, #422, #467, #439, #547, #557, #647, #691 30. PMM PST Review tracking Sheet, undated 31. Section T Settlement Agreement Cross-Referenced with IC-MR Standards, Revised February 2011 **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, Human Rights Officer 6. Four QMRPs 7. PST for Individual #442 **Meetings Attended/Observations:** 1. PSPs for twoIndividuals: Individuals #442 and #601 2. Personal Focus Assessment (PFA) meeting for Individual #561 3. Post Move Monitoring Visit for Individual #422 4. Human Rights Committee (HRC) 5. Quality Assurance Department staff presentation 6. At-Risk Assessment meetings for two individuals; Individuals #363 and #385
	Facility Self-Assessment: The Monitoring Team reviewed the RSSLC POI. Overall, the Facility indicated it was not in full compliance with any of the provisions of Section T. **For Provision T1**, the Facility indicated that it believed it was not in compliance with most of the sub-sections, with the exception of the issuance of the Community Placement Report. The Monitoring Team concurred with these assessments. The POI noted a number of actions the Facility had taken since the previous site visit, including the development of new policies and processes related to the Personal Support Plan and the recent implementation of the revised CLDP process and format. The Transition Coordinator was reported to be responsible for monitoring all parts of transition process to assure appropriate CLDPs were developed and services provided, and had begun completing pre-move site reviews to be sure needs for essential and non-essential supports could be met for individuals who would be transitioning. The POI also noted a number of training activities undertaken to educate staff on community living options and transition processes. **For Provision T2**, the Facility stated it was not in compliance with the PMM process. Actions reported in

	the POI included that new Post Move monitoring tools had been received and implemented, and that PMM visits were being completed as required. The Facility also reported it had begun tracking review by PST of all PMM monitoring reports. **For Provision T3**, no rating was required. **For Provision T4**,the Facility indicated it had no alternative discharges during the past six months.
	Summary of Monitor's Assessment: RSSLC indicated that it was not in compliance with any of the provisions of this Section, but did report it had achieved some level of compliance in one component area the Community Placemen Report under Provision T1. 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 RSSLC as it undertakes action in these provisions. The most significant finding was that the overall lack of rigorous and comprehensive assessment practices at the Facility, as evidenced throughout this report, had a detrimental impact on the implementation of the requirements of Section T. Specific findings are as follows: **Provision T1:** Fifteen individuals had transitioned to a community placement in the past six months, which was a relatively high pace, but this provision was determined to be not in compliance overall. In most instances this was consistent with the Facility's self-assessment. The Facility continues 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. There were improvements in the CLDP processes, but these continued to be hampered by the deficiencies in assessment practices at the Facility. The Facility had begun completing Facility Pre-Move Site Reviews for individuals who were moving to the community. In one such instance, the Pre-Move Site Review found that certain in-services that had not been provided, although the MRA Continuity of Care Pre-Move Site Review had not identified this issue. The move date was delayed as a result until the in-services were completed. This demonstrated the value of the Facility Pre-Move Site Review as a double-check mechanism. The Facility had undertaken much activity in providing staff in-service regarding most integrated setting, community living and transition, which was a positive step. The Monitoring Team commends the Transition Coordinator and the Facility for this initiative and would recommend that all of this activity be consolidated into an overall strategic plan for community education and awareness that also places an emphasis on promoting awareness and decision-making capacities for individuals. The Facility's draft policy on Community Exposure was one step in this direction, but may need to include additional details such as an expectation that each PST will develop a community exposure plan for each individual that is specific to his/her learning needs. The Facility reported it was in compliance with component T1h, the issuance of the Community Placement Report at required six month intervals. The Monitoring Team concurred. However, the Monitoring Team

	points out that while the Community Placement Report indicated that there were only two individuals included in that category, the Monitoring Team found that PSTs were not always accurately reflecting in their deliberations that the finding of the Facility as the most integrated setting was driven by the preference of the LAR. **Provision T2:** This provision was determined to be not yet in compliance. Overall, the Facility continued to be diligent in its efforts in this area, but it did not yet rise to the level of substantial compliance. The Monitoring Team found that the PMM Checklists were being completed in a timely manner. Although the PMM Checklists reviewed were being completed in a timely manner, the process used to complete them was not yet thorough or adequate to be able to state with certainty that the essential and non-essential supports were actually in place. The Post-Move Monitor still needed to provide more detailed documentation of follow-up for identified deficiencies in the provision of supports. The potential for PMM visits to be missed when the process took place across catchment areas appeared to have been resolved as the Facility reported it would only be monitoring individuals placed from RSSLC in the future. The Facility had begun to require and document PST review of the results of the PMM visits for each individual, but there was often a significant lapse of time between the PMM visit and the actual review by the PST. It was commendable that the Facility was requiring and tracking PST review, but it should clarify its expectations for the timeliness of the process. **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 not rated as no alternative discharges were reported. 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 T1d, and T1e and T2, for the individuals who are classified in the SA as alternate discharges. Such alternate discharges could occur at any point, and it is recommended the Facility have policies and procedures in place to define its processes. The draft DADS Policy 018: Most Integrated Setting Practices addresses the requirements for alternate discharges and provides a template for discharge summaries for these individuals in Exhibit F. Once formally promulgated, this policy should be sufficient to provide guidance for the development of the Facility-level policy and procedure.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**	This Provision was found to be not in compliance.	Noncompliance
T1a	Subject to the limitations of court-	RSSLC reported that 15 individuals had transitioned to the community in the past six	Noncompliance

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	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.	months. No individuals had returned from a placement, nor had any deaths occurred for individuals who had moved to community living within that time span. This was a relatively high number, and was at a pace consistent with the reported 13 placements during the previous six months. The Facility had continued to focus significant attention on community transitions, noting in its presentation on the first day of this site visit that 365 individuals had moved to the community from RSSLC since November, 1995. During this past six months, RSSLC had undertaken some 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 integratedsettings appropriate to their needs. • RSSLC had continued implementing the new statewide PSP process. According to the Report to Monitors provided at the entrance meeting, 98% of all 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 the supports and services needed by individuals in the most integrated setting. • The Facility had also begun monitoring the PSP process, using the PSP Checklist. See Provision F2g for additional detail. • RSSLC was providing considerable training for staff on most integrated setting and transition topics, as described in T1b2 below. These are positive steps, but 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. The Facility and its PSTs did not always proactively encourage individuals to the most integrated setting, including the following examples: • For Individual #274, the PSP dated 8/18/10 included an Action Plan that said the individual would have opportunities to visit group homes on a quarterly basis. The Monitoring Team requested documentation of these visits, which should have also included information provided to the PST regarding the individual's reaction to the visits and the PST deliberations in response. The only documentation provided was an attendance sheet for a single community group home tour that included 35 additional individuals. No evidence of PSP consideration of the visit was made available for review. • Individual #747 stated at the PSP a desire to move to a group home. The individual's family and LAR were opposed. The PST agreed that RSSLC would be the most integrated setting at the time based primarily on the LAR preference. The PST documented that a lack of education of alternative living was a great	

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		priority which it would address by providing education of alternative living settings through implementing smaller steps to assist both the individual and family to better understand community living. No such Action Plans were developed in the PSP.	
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. The Monitoring Team reviewed drafts of DADS Policy 018: Most Integrated Setting Practices, dated variously 1/27/10 and 0/00/11. This policy provided several updates to the previous version. RSSLC had revised a number of policies to reflect these statewide requirements, which were generally consistent with state-level most integrated setting policies, including RSSLC Policy F.4 Support Plan Process (Integrated Protections, Services, Treatments, and Supports)12/30/10; RSSLC Policy F.5 Completing Personal Support Plan Meeting Documentation 12/14/10; and, RSSLC Policy F.18 Participating in Personal Focus Assessment Meetings 4/20/11. These had not yet been effectively implemented as further described below.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The PSTs at RSSLC continued to need additional training and mentoring in the identification of protections, supports and services individuals will need in the most integrated setting, as well as in the identification of obstacles to movement to the most integrated setting. This is consistent with a need to improve their overall abilities to function as effective interdisciplinary teams in the assessment of individual needs and the supports and services needed at RSSLC, and in their understanding of their responsibility to complete a professional assessment of an individual's most integrated setting appropriate to his or her needs. These are described in more detail under F1e above. 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 preferences and needs. This vision was intended to be developed through the Personal Focus Assessment (PFA), completed by the individual, family, and PST during the third quarter review preceding the annual PSP. As described in section F1b, F1c and F1d above, the PFA process was not currently implemented in a manner that either was meaningful to the individual or likely to elicit information about the vision for the individual's future. In particular as it relates to the assessment of the most integrated setting and the protections, services, and supports that need to be provided, the PFA was not being implemented in a manner that would support these objectives. The PSP process was supposed to use the PFA to provide the PST with the individual's interest in pursuing alternate community living, along with a geographic location for possible future	Noncompliance

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		placement, prior to the annual planning meeting. This was intended to 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. As documented in F1c, the PFA was not being implemented three months prior to the meeting. As further documented in F2e, QMRPs did not seem to be aware of the purpose for this three-month timeframe. The Monitoring Team reviewed 29 PFAs that had been completed for upcoming PSP meetings to be held in the month of May. In addition to the issue of timeliness as identified above, there was very little evidence the process was conducive to and/or being used to examine alternate community living. There were only a few questions that specifically addressed community living options. One of these was "If you were to move from Richmond State Supported Living Center to live somewhere else, where would you like to live?" The PFA process tended to be one of rote questioning, and this question was not one that many individuals might understand without significant context and experience. As described in T1b2, RSSLC did not yet provide an enriched program that promoted awareness of community living options for individuals, so most did not have the requisite context and experience to make this a meaningful question. A review of the 29 PFAs indicated only four specifically suggested living in the community as an alternative. The PFA did prompt the PST to consider specific assessments that might be appropriate in advance of the PSP meeting. In terms of community living options, related assessments listed included Community Leisure Assessment, Community Awareness Assessment, Community Participation Assessment and Community Traffic Safety Awareness. For the 29 PFAs reviewed, only seven (24%) recommended any of these assessments be completed. For the four that had suggested living in the community as an alternative, none (0%) recommended any of the community-related assessments be completed. The rote questioning process by which the PFA was implemented was also unlikely to support adequate participation by an individual overall. The Monitoring Team reiterates its recommendation that 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 Monitoring Team recommends that the Facility implement a formal curriculum for "planning my future" that is incorporated into the overall active treatment program on an ongoing and regular basis. Information regarding person-centered training models that might assist QMRPs to better facilitate this process may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html. Additional details as to this recommendation may be found in F1b.	

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		The Monitoring Team attended one PFA and two PSP annual planning meetings and reviewed 14 PSPs completed using the new process and format for the purpose of evaluating this component. Consistent with the findings under Provision F, the PSTs did not exhibit proficiency in the assessment of the most integrated setting appropriate to an individual's needs, the identification of needed supports and services in that setting other than those things being provided at the Facility, or the obstacles and/or strategies to overcome those obstacles. Examples included: • As reported in F1e, for Individual #442, the PST concluded during the PSP meeting that the most appropriate living option for the individual was RSSLC, although there was no significant information presented that appeared to preclude community living other than the expressed preferences of the family, LAR, and individual for continued residence at the Facility. Following the meeting, the Monitoring Team questioned the PST as to their professional assessment of the most integrated setting for the individual. The unanimous response of the team was that community living would be the most integrated setting. The PST indicated it did not understand it was supposed to identify the most integrated setting from its professional perspective if the LAR or family was opposed. Once this was clarified, the PST noted in the final PSP document that it felt the individual could be served in the community with appropriate supports. It then went onto say the individual and the guardian wanted the individual to remain at RSSLC and that the "PST therefore agreed with (the) guardian that the most integrated setting for (the individual) at this time is his current home…" For Individual #442, the PST identified the guardian's preference that the individual remain at RSSLC as an obstacle to the Optimistic Living Vision of a community setting. The PST did not develop any individualized, observable and/or measurable goals/objectives or any treatments or strategies to be employed to address this obstacle. • For Individual #175, the PST indicated the most appropriate living option at the time of the PSP was to continue to live at RSSLC. No rationale for this determination was provided. Under the section for identifying obstacles and the plans to overcome the obstacles, the only statement was "none." Under supports needed to educate individual and/or LAR regarding living options, the PST indicated the individual would need to continue current training programs, have new programs to educate the individual on community living options, and continue attending off campus trips and group home tours. The Action Plans developed for this PSP did not address group home tours or any new programs to educate the individual on community living options. The only new activity related to the community was to begin trips to get ice cream once per month.	
	2. The Facility shall ensure the	The Monitoring Team reviewed documents related to education and awareness activities	Noncompliance

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	provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	and interviewed the Transition Coordinator. The Facility needed to place additional emphasis on the development of robust and individualized community awareness strategies for individuals. In response to the document request for a list of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices, the Facility provided several documents. One of these was a list that included 8 CLOIP tours that had been made available between 11/05/10 - 01/10/11. The Facility also provided some additional documentation on-site, for a total of 12 CLOIP tours provided between 11/05/10 – 5/04/11. While it was not clear that precise documentation was kept regarding the individuals and staff involved in the tours, it appeared that 140 individuals and 25 staff had participated. Some of these tours were made in groups of 20 or more, which may not be the most conducive to understanding the actual experience of community living options. For example, one of the advantages to living in a group home is the small size and the potential for additional privacy and quiet environment. A large group tour would not allow individuals to sample this experience. The Facility had drafted a policy on Community Exposure that was made available to the Monitoring Team for review. This draft policy summarized some requirements and assigned certain responsibilities for the CLOIP tours. These included scheduling of the tours assigned to the contract MRA, who would forward this information to the Transition Coordinator at RSSLC. The Transition Coordinator, in turn, would send the tour information to the Social Worker, Recreation Coordinator and QMRPs for each unit. The Social Worker would then coordinate with individuals and QMRPs to schedule individuals to participate. The Social Worker or designee would also be required to attend all CLOIP tours for the individuals they served, to record tour participation, to forward the signature sheets to the Transition Coordinator on a monthly basis, and to work with other tour participants to complete the tour impressions form and forward these to the Transition Coordinator within two working days of the tour. The policy did not describe what use the Transition Coordinator would make of these forms, or how they might inform PST deliberations. It was also noted that the Recreation Coordinator would provide feedback to the PST through the "Learning Log" process. This draft policy was a good starting point but may need to include additional details such as an expectation that each PST will develop a community exposure plan for each individual that is specific to his/her learning needs. The annual MRA CLOIP process continued to comprise a significant portion of the Facility's overall plan for education and awareness for individuals but perhaps should not be viewed as the primary vehicle to meet the learning needs of individuals who live at the Facility. The Monitoring Team requested a sample of CLOIP Worksheets completed for PSPs held in the month of April 2011. For 11 of the 25 (44%), the LAR did not allow the MRA Service Coordinator to provide the individual with information about living options. For 10 of the remaining 12 in which the MRA did engage the individual in	

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		the CLOIP, the MRA Service Coordinator documented the individual had no response, the individual's response was unknown and/or the individuals did not seem to comprehend the materials or information being offered. This would suggest that there should be some consideration given to assessing how the materials and information should be modified to better meet the needs of the individuals. As discussed in more detail in U2, the Facility has committed significant staff time and resources to the promotion of self-advocacy, which can support the development of enhanced decision-making skills and capacity. The Monitoring Team reviewed the minutes of self-advocacy meetings that had been held over the past six months. While it was clear that individuals were encouraged to take an active part in the proceedings, there did not appear to be a consistent approach to teaching specific self-advocacy skills. It is recommended that the Facility evaluate options for using a formal decision-making curriculum as a part of its self-advocacy program, as this will also support the ability of individuals to make decisions for themselves as to where they would like to live. This should be incorporated with more formal decision-making programs throughout, which may include the recommended "planning my future" curriculum as described in F1e and T1b1. An annual MRA In-service Training was held on 5/4/11. The Monitoring Team reviewed the presentation materials and attended one of the two sessions. The curriculum included information on the Home and Community Based Services Medicaid Waiver program, Community IDD Services, and access requirements for various levels of services. According to the sign-in sheets, a total of 105 people attended the in-service, including both staff and individuals. These may have been more useful if they had focused on the kinds of questions individuals and PSTs have about the realities of services that can be provided in the community. According to the Transition Coordinator, the latter was what she had been hoping for. There had been a number of training opportunities about most integrated setting and transition for staff in the past six months. These included a well-attended in-service on Living Options/Transition Training by Donnie Wilson from DADS state office, as well as several sessions on the CLDP process, the PST Review of PMM reports, referral and move addendums and the new CLOIP tour process provided by the Transition Coordinator. The Monitoring Team commends the Transition Coordinator and the Facility for this initiative and recommends this continues in concert with an education and awareness strategic plan described in the next paragraph. Overall, RSSLC had taken some actions to increase education and awareness about community living options over the past six months but still did not have a robust and enriched program that specifically addressed the learning needs of each individual. The	

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		Monitoring Team recommends once again that the Facility develop a comprehensive strategic plan for education and awareness. This strategic plan should promote awareness, with assigned responsibilities, timelines and outcome measures. Partners in this effort should include all those with responsibility for education and training: the Transition Coordinator, the Post-Move Monitor, the QMRP Educator, the Competency Training and Development department at the Facility, and the Contract MRA and other MRAs, with input from self-advocates at the Facility. PSTs should receive additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The Facility stated in its POI that there was no assessment for transition, but that this information was being captured in the Living Options discussion, and this discussion occurred annually for all individuals, but the Facility did provide, in response to the document request for its assessment process, the Community Living Options Discussion Record (CLODR). This process takes place at least annually as a part of the PSP as described in Texas DADS SSLC Policy 018: Most Integrated Setting Practices, 3/31/10. The Facility provided a list of 405 individuals who had been assessed for placement in the past 12 months using this definition. If the Community Living Options discussion was implemented in such a manner that it could be considered an effective assessment for placement, the Facility would have fulfilled this requirement. From observations and document reviews as described in F1e and T1b above, this did not yet appear to be the case. T1b1 details the failure of the PSTs to adequately implement this portion of an assessment process. 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. These improvements should begin with a clarification and additional training for PSTs on their responsibility to assess each individual for the most integrated setting appropriate to their needs, combined with a focus on the ability of the PSTs to engage in critical thinking, interdisciplinary assessment and actual person-centered planning. This will require considerable staff training and mentoring.	Noncompliance
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	This component was found to be not in compliance. The Facility did not always ensure that PST identification and recommendation of an appropriate integrated community setting resulted in a timely placement within the 180 day timeframe required by Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10.The Monitoring Team reviewed the Community Placement Report, dated March 2, 2011. Of the ten community transitions that had occurred from 10/1/10 through the date of the report, five (50%) were completed within the 180 day timeframe. Of the fifteen current active referrals listed in the report, one (7%) had exceeded the 180 days. The Facility should ensure that tracking timeliness of actions related to referrals and community placements	Noncompliance

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	community living discharge plan in a timely manner. Such a plan shall:	is included in its development of the quality assurance procedures required under Section T1f. The Facility had recently begun to use in a new and expanded CLDP process and format. The CLDP instructions for completion require that: 1. Development of the CLDP should begin at the time of the referral for alternate community placement and should continue past the transition date. 2. The CLDP should be completed using the person directed planning philosophy. 3. PSTs will meet at various stages of the community transition process. 4. Deliberations from these meetings will be captured in the CLDP. 5. Direction from the individual and/or LAR (if applicable) should be solicited and documented at each stage of the process Only one CLDP had been fully completed with the new process. As the Facility had only recently begun to phase in these improvements to the process, it was not possible to adequately assess compliance at this site visit. The Monitoring Team will look forward to reviewing the Facility's progress at the next visit.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The CLDP 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 PST did appear to rely heavily on the PSP and the assessments associated with the PSP to guide the identification of the essential and non-essential supports. 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 described in Section T1b, Section F1c and Section F2a. Examination of this element of the Settlement Agreement will therefore be contingent to some degree on a positive evaluation of these items at some point in the future. In terms of thoroughness, the PST still failed to identify important issues in its listing of essential and non-essential supports. In developing a CLDP that takes advantage of the opportunities inherent in community living, it is also important that PST members be aware of the types of services and supports that are available in the community. In general, the PST tended to identify only those things that are currently provided at the Facility. This could result in many missed opportunities for individuals to have supports that expand on their experiences. The Monitoring Team reviewed five recently completed CLDPs for individuals who had	Noncompliance

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		already moved to the community. The listing of essential and essential supports did not always adequately capture basic requirements for a successful transition, nor did it contain enough specific guidance to the Post-Move Monitor as to the evidence that would be needed to ensure the supports and services were being provided appropriately. As an example, for Individual #246, the CLDP documented the individual required a ground texture diet, no rice, with liquids thickened to honey consistency; wedge to elevate head of bed; gait belt; plate guard and Good Grip teaspoon. The listing of essential supports simply required "(s)taff provided training and knowledgeable of information contained in CLDP including: diet texture; feeding techniques; needs, preferences, etc; and (s)taff knowledgeable of diet and adaptive equipment." The only evidence required for either of these was a staff in-service sheet. If these supports are considered essential to the individual's safety and successful transition, the PST should list them clearly to ensure they are not inadvertently missed. The PST should also be more specific about how the Post-Move Monitor could adequately evaluate the implementation of these supports. At a minimum, evidence should include observation for the presence of any essential adaptive equipment or materials and questioning and/or observing staff to ensure they are knowledgeable. This should be in addition to the review of an in-service signature sheet.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	For none of the five CLDPs reviewed (0%) did the Facility consistently assign specific Facility staff responsibility for each of the essential and non-essential supports. Instead, staff from the selected provider were often 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. 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. The implementation of the Facility Pre-Move Site Visit may provide an avenue for designating the responsibility of Facility staff.	Noncompliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The Monitoring Team reviewed the attendance signature sheets for five completed CLDPs for evidence that the individual and, as appropriate, the LAR had participated in the CLDP. For four of five (80%) the individual participated. The LAR/family member had participated in four of five CLDPs (80%). There was narrative in the CLDP that described their participation in the transition planning process. The new CLDP format and process calls for solicitation and documentation of direction from the individual and/or LAR (if applicable) at each stage of the process. The Monitoring Team found that in the single CLDP completed in the new format, documentation was provided of team deliberations throughout the process. There was also one CLDP in process, for Individual #252, which was reviewed. As required, the CLDP had documented deliberations on an ongoing basis for the most part.	Noncompliance

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		The only exception to this was the documentation regarding the PST meeting to review current assessments. The CLDP indicated the PST meeting was held on 4/06/11, but there were no minutes or other documentation of this review. This was of particular concern because the individual had a medical issue that needed to be addressed. As described further in T1d below, it was not apparent that the PST had actually completed an interdisciplinary review, as there had been no follow-up scheduled regarding this medical need, nor consideration of its potential impact on the individual's transition to the community, until it was brought to the attention of the Facility by the Monitoring Team. There was no documentation of review of the 45-day assessments with the individual or family/LAR.	
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. There was improvement in the Facility's process for ensuring the required 45-day comprehensive assessment documents were obtained and reflected in the CLDP documentation. The Transition Coordinator had implemented a CLDP Assessment Tracking Sheet to facilitate the timely submission of these reports. Obtaining updated assessments from various professionals and ensuring they are available at the CLDP and for the use of the selected provider is an important step. However, as described in T1c3 above, these were not always being integrated into a comprehensive assessment in a manner that allowed for the CLDP to accurately reflect the needs and supports to be provided in the community setting. In order to be considered a current and comprehensive assessment of needs and supports, the findings and recommendations must be accurate and reflect all significant information the PST and the community provider would need to develop an appropriate transition plan. The following narrative illustrates this point. For Individual #252, a PSP was held on 5/4/11 and Community Living Discharge Plan (CLDP) was to be held on 5/06/11. The individual had experienced rectal bleeding beginning in December 2010, was scheduled for a colonoscopy in March, 2011 that could not be completed and had an ultrasound on 4/15/11 that revealed a possible mass. No additional follow-up had yet been scheduled. The QMRP reported that the PST had agreed at the PSP meeting that this could wait for follow-up until after the individual moved to his new community home, which would be a minimum of two to three weeks following the CLDP. This would mean a delay in diagnosis of many months, which would not be consistent with standards of care. Once this was brought to the attention of the Facility by the Monitoring Team, a follow-up was scheduled. Despite the scheduling of the follow-up, the Monitoring Team remained concerned that the CLDP process had failed to identify this significant health concern just two days before the CLDP meeting was to be held, even though the Medical Summary, which referenced the condition, was completed on 4/28/11. The final CLDP meeting is not typically held until the provider has been selected and transition to the community	Noncompliance

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		setting is imminent. In this case, there was potential that a health condition requiring extensive treatment was present. This may have, in turn, drastically changed the support needs of the individual, at least in the near term. It was reported by the individual's QMRP that the provider was present at the PSP meeting and must have then received the message that the condition was such that follow-up could wait. The provider was not sufficiently informed of the potential nature of the individual's needs. Given that the PST had downplayed the potential seriousness of the issue just two days prior to the CLDP meeting, it was questionable whether it would have been identified at the CLDP meeting, which must rely on the input of the PST.	
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 reviewed documentation of the MRA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for ten individuals who had transitioned to the community in the last six months. 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. The instrument also calls for the MRA to attest it has verified the provider is in good standing with DADS, using the DADS Quality Reporting System website, and to attach the printed verification. Only one of the ten was not attached to the instruments made available to the Monitoring Team for review. The revised CLDP process also required the Facility to also complete its own pre-move site visit prior to the individual's transition date. For four of ten individuals, these were not provided to the Monitoring Team for review. This may have been a function of the phasing in of this recently implemented process, although there were some Facility Pre-Move Site Reviews completed in December 2010and January 2011 made available for review, but some were missing in February and March. As a general rule, the Facility Pre-Move Site Reviews did not provide any additional information as compared to the MRA Continuity of Care Pre-Move Site Review Instruments. For one of six completed Facility Pre-Move Site Reviews, there were notes regarding in-services that had not been provided even though the MRA Continuity of Care Pre-Move Site Review had not identified this issue. The move date was delayed as a result until the in-services were completed. This demonstrated the value of the Facility Pre-Move Site Review as a double-check mechanism. The Monitoring Team will look forward to reviewing this process when it is fully and consistently implemented.	Noncompliance
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	This component was found to be not in compliance. RSSLC did not have adequate quality assurance policies, procedures and/or processes to ensure that community living discharge plans were developed, and that the Facility implemented the portions of the plans for which the Facility was responsible. The Transition Coordinator had implemented a tracking system for the 45-day	Noncompliance

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	plans for which the Facility is responsible, consistent with the provisions of this Section T.	assessments, which was a positive step. The reviews of the CLDPs from this site visit, as described in sections T1d and T1e above, and of the progress of referrals, as described in Section T1c, would suggest the Facility needed to develop or otherwise promulgate additional quality assurance procedures that would ensure CLDPs are tracked from the process of referral through move to the community. This should include written procedures for ensuring, at a minimum: • PST recommendations for community living for individuals result in a timely meeting with the Designated MRA to consider making the referral; • Referrals are routinely tracked and are completed within the 180 day timeframe unless a waiver is granted; • CLDPs routinely 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.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance	This component was found to be not in compliance. In response to the document request for this item, the Facility indicated that no facility-wide needs assessment had yet been developed. Community Placement Obstacles were documented only for individuals who had a preference for community placement, but were not recommended by the PST. The Community Placement Obstacles report, dated March 21, 2011, listed such barriers for only nine individuals. This was not a sufficient approach to the requirements of the provision. The Facility mustgather obstacle data on a comprehensive basis, and 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 to DADS. The analysis should be predicated on a consistent methodology for collecting information that is described at the outset of the report. Examples of possible sources for relevant data that could inform a truly comprehensive assessment include: • Barriers perceived and/or encountered by individuals, families and LARs, as documented by the PSTs and through Parents and Self-Advocacy groups • Post-Move Monitoring Checklists could be analyzed and common issues identified. 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	Noncompliance

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	from other agencies or the legislature.	addressed both in the catchment areas and the state as a whole. The methodology 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 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." The PSTs will need further training to adequately perform these tasks that form the basis for obstacle identification.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services	The Facility issued a Community Placement Report on March 21, 2011, covering the period of 9/1/2101–3/21/2011. The report was in the standardized format as prescribed by DADS State Office. It listed: • Ten community placements • Fifteen current referrals • Two rescinded referrals • Two individual prefers community, not referred-LAR choice • Five Individual prefers community, not referred-other reason • Zero in the category of LAR prefers community – not referred The Monitoring Team concurred with the Facility's assertion of substantial compliance for this provision. However, as described in T1b1 and F1e, PSTs did not always understand their responsibilities in identification of the most integrated setting appropriate to an individual's needs, and frequently deferred their own assessment based on the stated preference of the LAR. This was observed during the PSP meeting for Individual #442, in which the PST determined during the meeting that RSSLC was the most integrated setting. When questioned after the meeting, the PST agreed the individual could be appropriately served in the community, but indicated they had made the earlier determination based on the LAR's stated preference. In addition, the Monitoring Team found that there were individuals for whom the PST documented RSSLC had been determined to be the appropriate most integrated setting due to LAR choice, but these individuals were not listed on the Community Placement Report. For Individual #231, the PSP documented that the PST determined RSSLC to be the most integrated setting at the current time due to the individual's "mother and guardian preferred that (the individual) not be considered for community placement." These	Substantial Compliance

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	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.	findings called into question the accuracy of the data the Facility is receiving from the PSTs regarding those who are not referred solely due to LAR choice. It is recommended that additional training be provided to PSTs regarding their responsibilities related to identification of an individual's most integrated setting and the documentation required to track this information.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	This component was found to be not in compliance. The Monitoring Team interviewed the Post-Move Monitor and reviewed the PMM checklists for eleven individuals, all of whom received monitoring by the RSSLC Post-Move Monitor. The Monitoring Team found that the PMM Checklists were generally being completed in a timely manner. The potential for PMM visits to be missed when the process takes place across catchment areas appeared to have been resolved, as it was reported that the Facility provided monitoring only for individuals who transitioned from RSSLC beginning on 4/1/11. Some deficiencies in the process remained. The Post-Move Monitor did not always visit each of the sites in which supports were to be provided. The PMM process was designed to be intensive during the critical 90 day period following transition. The Post-Move Monitor did observe the individuals in their new home environments at all 7-day visits, but for four of eleven (36%) individuals, only the home was visited at that time, but not the day program For three of seven (43%) in which the 45–day visit had already been made, the Post-Move Monitor documented that she visited the day habilitation program only but not the home. The Post-Move Monitor must personally ensure that supports are available and being provided in the appropriate and prescribed manner in all sites in which the supports are called for at each of the required visits. The draft DADS Policy 018: Most Integrated Setting Practices, dated variously 1/27/10 and 0/00/11, provided in Section VII.B. that on-site reviews of both the residential and program sites are required. The Monitoring Team concurs with this requirement. The Monitoring Team found that the Post-Move Monitor was typically diligent in checking all the supports that were to be provided at the sites she did visit; however, there were some instances in which supports were not checked. Examples included: • For Individual #467, the essential supports included "staff knowledgeable of	Noncompliance

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		adaptive equipment (plate guard – to be used on of (sic) plate not bottom, Dycem mat, Big care spoon, Right resting hand splint to be worn during afternoon day programming sessions." The Evidence column on the revised PMM Checklist indicated in-service sheet to be the required evidence. In the Comments section, the Post-Move Monitor wrote "In-service 12/8/10." The Post-Move Monitor should have at least observed for the presence of the adaptive equipment and questioned staff as to its appropriate use. In the case of the resting hand splint to be used during afternoon day program hours, the Post-Move Monitor could not have accounted for its presence or its use, because only the individual's residence was visited. • For Individual #647, the PMM Checklist required a clutter free environment and that the staff be trained to maintain a safe environment and materials due to a history of PICA. The PMM documentation for the 7-day visit indicated the home was clutter-free, but did not address the staff training requirement. For this individual, the Post-Move Monitor did not visit the day habilitation program until the 45-day visit, so she was unable to account for this essential support in that setting. The Monitoring Team interviewed the Post-Move Monitor regarding these issues related to follow-up and documentation. The Post-Move Monitor had taken some actions and maintained emails and phone logs that would document some additional follow-up at times. In addition to ensuring that all necessary follow-up is completed, the Post-Move Monitor should continue to carefully document the follow-up, including date and response to action taken. Emails and phone logs related to the follow-up should be attached, maintaining all documentation related to PMM as a complete record. The Facility reported it had begun to require and document PST review of the results of the PMM visits for each individual. A spreadsheet was provided for the Monitoring Team to review. It indicated there was often a significant lapse of time between the PMM visit and the actual review by the PST. It was commendable that the Facility was requiring and tracking PST review, but it should clarify its expectations for the timeliness of the process.	
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	This component was found to be not in compliance. The Monitoring Team accompanied the Post Move Monitor on a 90-day PMM visit for Individual #422 on 5/2/11. The Post Move Monitor generally continued to be diligent and thorough in her duties, reviewing both the PMM Checklist and the CLDP to identify the supports and services that should be present. Most of the required essential and nonessential supports were verified through a combination of observation, interview with the individual, provider interview and record review.	Noncompliance

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	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.	There were still some deficiencies noted in the process, despite the overall attention to detail. For example, the individual required egg substitute. The Post Move Monitor asked to see whether the product was available, but did not examine the carton or notice that it was "real egg" product until the Monitoring Team questioned it. At that point, it appeared neither the Post Move Monitor nor the provider staff were sure if this was the correct product needed. A review of the CLDP and the accompanying nutrition assessment indicated the individual had high cholesterol and was prescribed a diet with egg substitute. The rationale provided was to reduce serum cholesterol. Follow-up should be completed to clarify for the provider staff what products are acceptable for use. The CLDP also called for the individual to participate in self-administration of medication and to receive supports to enhance peer relationships, but the Post Move Monitor did not specifically inquire about either of these. Consistent with the findings in T2b, the Post Move Monitor did not include the day habilitation program, as required in the DADS Policy, in the visit made on this date. The Post Move Monitor indicated to the individual this would be the last visit she would make with her. When the Monitoring Team brought to the attention of the Post Move Monitor that she needed to include all sites at which the individual received supports and services, she stated she sometimes split a visit across days and would do that for this final visit. This would be an acceptable approach, as long as both sites were visited within the 90-day timeframe for this individual. A review of 18 PMM Checklists for eleven individuals completed between 1/11 and 4/11 indicated there had been no instances in which a required review took place on separate days to cover home and day program, although there were examples of the two sites being visited several hours apart. The visit to the day program in this instance had not yet been scheduled. Many of the supports being provided to the individual were reported by staff to be occurring at the day program, so it was essential such a visit be made. The visit to the day program was scheduled and completed as required once brought to the attention of the Post Move Monitor.	
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,	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. RSSLC reported it had no individuals who fell into this category.	

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	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.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	This provision was not rated. RSSLC reported that no individuals have been discharged pursuant to an alternative discharge as defined in the Settlement Agreement. The Facility did not currently have a policy and procedure in place describing how it would comply with the requirements of this provision if such a circumstance arose. As it is possible that such an alternative discharge could occur at any time, it is suggested a Facility policy and procedure should be in place to identify how the Facility will identify alternate discharges and implement discharge procedures consistent with CMS-required discharge planning procedures. The draft DADS Policy 018: Most Integrated Setting Practices, dated variously 1/27/10 and 0/00/11, Section VII, addresses the requirements for alternate discharges and provides a template for discharge summaries in Exhibit F for these individuals. Once formally promulgated, this policy should be sufficient to provide guidance for the development of the Facility-level policy and procedure.	Not Rated

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. There should be some consideration given to assessing how the CLOIP materials and information should be modified to better meet the needs of the individuals. MRA CLOIP staff may benefit from additional training in recognizing opportunities to continue a conversation about community living and how to appropriately address them.
2. In its draft policy on Community Exposure, the Facility should include additional details such as an expectation that each PST will develop a community exposure plan for each individual that is specific to his/her learning needs.
3. The Facility should develop a comprehensive strategic plan for education on community living options with assigned responsibilities, timelines and outcome measures. PSTs should receive additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs.
4. 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.
5. The Facility should ensure that data regarding individuals who are not referred for community living solely due to LAR choice are accurately reflected in the Community Placement Report. Additional training should be provided to PSTs regarding their responsibilities related to identification of an individual's most integrated setting and the documentation required to track this information.
6. The Facility should ensure that timeliness of actions related to referrals and community placements are included in its development of the quality assurance procedures required under Section T1f.
7. Facility policy and procedure should specify the expectations that Facility staff have responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness of the supports specified in the CLDP. The implementation of the Facility Pre-Move Site Visit may provide an avenue for designating the responsibility of Facility staff.
8. The Post-Move Monitor must personally ensure that all supports are available and being provided in the appropriate and prescribed manner in all sites in which the supports are called for, and at each of the required visits.
9. In addition to ensuring that all necessary follow-up is completed, the Post-Move Monitor should continue to carefully document the follow-up by filling in the Action/Follow-up section of the Checklist, including date and response to action taken. Additionally, emails and phone logs related to the follow-up should be attached. It is also recommended that DADS state office incorporate its expectations regarding this documentation into its statewide policy and procedure.
10. The Facility should clarify its expectations for the timeliness requirements for PST review of PMM results.

The following are offered as additional suggestions to the facility:

1. The Monitoring Team recommends that the Facility implement a formal curriculum for "planning my future" that is incorporated into the overall active treatment program on an ongoing and regular basis. Information may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html.
2. The Facility should evaluate options for using a formal decision-making curriculum as a part of its self-advocacy program, as this will also support the ability of individuals to make decisions for themselves as to where they would like to live. This should be incorporated with more formal decision-making programs throughout, which may include the recommended "planning my future" curriculum as described immediately above.
3. 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), updated 4/18/2011 2. RSSLCSettlement Agreement Status Update, dated May, 2011 3. List of Legal Guardians Assigned for 240 individuals, dated 5/2/2011 4. Prioritized list of 168 individuals who are in need of an LAR 5. A list of seven individuals for whom an LAR or advocate has been obtained since October 2010 6. A list of Advocate Referrals, dated 3/2/2011 7. PSP Addenda requests related to advocate referrals for 33 individuals 8. Rights Assessments for 12 Individuals: Individual #30, #84, #213, #227, #360, #384, #402, #440, #513, #641, #679, and #798 9. DADS draft Policy Number: 019 Guardianship, undated 10. DADS draft Policy Number: 019 Rights and Protection (including Consent & Guardianship), dated 6/11/10 11. DADS draft Policy: Advocacy Program Policy and Procedures, undated 12. Signature sheets for New Employee Orientation dated 2-3-11 and 3/3/11 13. Sign-In Sheet for RSSLC Family and Friends meeting, dated 3/20/11 14. Minutes of Self-Advocacy meetings held since 12-01-10 **People Interviewed:** 1. Jim North, Human Rights Officer (HRO) **Meetings Attended/Observations:** 1. PSPs for 2 Individuals: Individuals #442 and #601 2. Human Rights Committee (HRC) Meeting for Individuals #360 and #641
	Facility Self-Assessment: The Monitoring Team reviewed the RSSLC POI. RSSLC indicated it was not yet in compliance with any of the provisions for Section U. The Monitoring Team concurred with this assessment. The POI indicated that the DADS State Office workgroup is continuing to work on development of statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the Settlement Agreement, and that it was awaiting this final guidance prior to implementing significant changes. The Facility had updated the prioritized list of individuals in need of a guardian due to people moving to community, although it was noted during the review the list may need to be updated again to delete individuals who have obtained guardians. The POI 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. For example, the HRO had begun to provide training on guardianship and advocacy at New Employee Orientation. The HRO had also taken some preliminary actions to prepare for the development of an advocacy program. These included meeting with the Director to discuss the current Advocate Program, returning current Advocate referrals to QMRP's to complete addendum to let Personal Support Teams (PSTs) know that the advocate program needed to

	be developed before referrals are made, and monitoring the completion of these addenda. Although this latter step was noted to have been completed on the POI, a review of the 33 addenda provided to the Monitoring Team revealed that eleven were not completed by the individuals' PSTs. This also did not account for all 47 of the individuals named on the Advocate Referrals document dated 3/2/2011.
	Summary of Monitor's Assessment: RSSLC indicated it was not yet in compliance with any of the provisions for Section U. The Monitoring Team concurred with this assessment. The POI indicated that the DADS State Office workgroup is continuing to work on development of statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the SA. During on-site interview, the Facility reported it was awaiting this final guidance prior to implementing significant changes.The Monitoring Team reviewed a sample of documents in order to be able to assess progress, if any, from the last compliance tour and provide any additional recommendations that may be helpful to the Facility when it does undertake further action in these provisions. The findings are as follows: **Provision U1:** This provision was determined to be not in compliance. The HRO had been designated with the responsibility for the requirements of this provision. The Facility did maintain a list of individuals needing an LAR, but there was still no standardized approach to assessing and determining the actual need for an LAR on an individualized basis that was consistent with commonly accepted professional standards of practice. The Monitoring Team found that, consistent with the lack of a robust and thoughtful approach to assessment in many areas as documented throughout this report, the PSTs did not adequately assess decision-making capacities nor develop appropriate action plans to address deficits. The most recent version of a draft statewide policy on guardianship did not contain any further substantial guidance for the PSTs in terms of a standardized tool and/or process, a much needed resource in the opinion of the Monitoring Team. It was reported that there was also a pending draft of a statewide Rights Assessment Policy which may provide additional guidance in this area, but this was unavailable for review. On a positive note, the Facility continued to offer significant opportunities for self-advocacy, which the Monitoring Team found very commendable. The HRO had also begun to provide training on guardianship and advocacy at New Employee Orientation. The Monitoring Team commends this initiative, which may positively impact the thoughtfulness of deliberations of the PST when they are considering the need for guardianship. **Provision U2:** This provision was determined to be not in compliance. The HRO had met with the Friends and Family Association to provide an overview of the Guardianship Committee that is expected to be rolled out with the pending Guardianship Policy. The Facility had also posted an announcement on the entrance marquee to solicit interest in becoming a guardian or advocate. There was otherwise little activity toward the solicitation of guardians for individuals during this review period. It was reported seven guardians had been obtained, and one successor guardianship was in process for an individual who had previously been adjudicated as in need of an LAR. As part of the Facility undertaking an effective and appropriate large-scale effort to solicit guardians, the Facility should ensure it has an appropriate methodology in place to determine the actual need for guardianship and to educated potential guardians as described above. DADS

	should complete development of policy, including guidance on such a methodology, as soon as possible.

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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.	RSSLC did not have a policy and procedure describing its processes for developing and maintaining 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 HRO reported that a statewide workgroup was continuing to work on a draft policy to implement the requirements of this provision. The HRO further stated that there is a June 1, 2011 deadline for submission of revisions to be included for the final review for this statewide policy. The Monitoring Team requested a copy of the current draft statewide policy and received DADS Policy 019: Guardianship. It was undated. This draft policy had changed rather significantly from a draft that had been previously circulated for review by the Monitors, Policy Number: 019 Rights and Protection (including Consent & Guardianship), dated 6/11/10. The stated purpose of this new draft of Policy 019 was "…to ensure that individuals residing in State Supported Living Centers (SSLCs) and their legally authorized representatives (LARs) and correspondents are made aware of guardianship services available in Texas and to identify those individuals without a LAR who would benefit from having an LAR to help them make decisions regarding treatment and programming." The draft policy did not provide substantial guidance to the Facilities and the PSTs in how to assess an individual's need for guardianship. No standardized tool or process was described for PSTs to use in making these determinations. Rather, it states "…the personal support team (PST) will discuss the individual's capacity/incapacity to make decisions regarding the individual's health and welfare." For individuals who do not currently have an LAR, the PST is instructed as follows: "If the individual does not have a LAR, is unable to give legally adequate consent, and is able to express his/her wishes verbally/gesturally/via a communication device/etc., the PST will need to discuss with the individual the role of a LAR as it relates to decision making, and make a determination of whether or not the individual would benefit from a LAR." "If the individual does not have a LAR, is unable to give legally adequate consent, and is unable to express his/her wishes verbally/gesturally/via a communication device/etc., the PST will need to deliberate on the appropriateness of a LAR for the individual…" In the previously circulated draft of the DADS draft Policy Number: 019 Rights and Protection (including Consent & Guardianship), the state had offered considerably more	Noncompliance

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		specific guidance for the teams, a much needed resource in the opinion of the Monitoring Team as had been described in prior reports. For example, the previous draft had included the use of specific standardized tools for assessing differential levels of capacity to make decisions. The current draft did not. It was reported by the HRO that an additional policy on Rights Assessment was being developed. DADS should ensure the PSTs receive adequate guidance in this area. The Monitoring Team found that, consistent with the lack of a robust and thoughtful approach to assessment in many areas as documented throughout this report, the PSTs did not adequately assess decision-making capacities nor develop appropriate action plans to address deficits. Facility PSTs continued to need such guidance, as well as training, from DADS to prescribe a process for how an assessment should be accomplished 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. During this site visit, the PSTs were not using an individualized assessment process to determine that an individual was in need of an LAR or to what extent or for what discrete purposes guardianship was required. The PSTs continued to address the ability of an individual to provide informed consent in the annual Rights Assessment, but this process was not predicated on any objective criteria. The HRO reported a statewide workgroup was preparing a draft policy on Rights Assessment, but this was not available for review. It was not clear how this policy might address the ability of the PSTs to make a differential assessment of the need for assistance with decision-making. The Monitoring Team looks forward to review of this updated policy and any accompanying tools in the future. The Monitoring Team attended the HRC meeting held for Individual #641 for the purpose of reviewing the Rights Assessment. The Informed Consent section of the Rights Assessment had checks in all six of the categories, indicating the individual was not capable of giving informed consent in any of these areas. For each of the categories, there was a comment given as to the manner in which the PST made the determination of the inability of the individual to give informed consent. For the category of Photo/Media, the Rights Assessment documented the individual was asked if it would be permissible to take a photo of the individual for the newspaper. The individual's reply was "No, don't take that picture." It was not clear from the documentation why the PST concluded from this exchange that the person was unable to make an informed decision in this regard, nor was the QMRP able to offer a rationale for this seeming contradiction. It is possible the PST had other factors it considered, but this was not documented. It is recommended that the PST for this individual review the Rights Assessment again and re-consider the individual's capabilities, at least in this area.	

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		It was also notable that the HRC did not identify this discrepancy in its review process. It is recommended the HRC members receive some additional technical assistance in the rights review process, particularly as it relates to providing a more rigorous assessment of the information being provided to them by the PSTs. This is consistent with the finding in Section F1d that the HRC failed to recognize the discrepancy that Individual #641 had a rights restriction in money management because he would give his money away, but that the strategies the PST developed intended to address focused on learning who to ask if he wanted to know the amount in his trust fund.. In addition to attending the HRC review of the Rights Assessment, the Monitoring Team reviewed 11 additional recent Rights Assessments that had occurred from January through April 2011. For 11 of 11 (100%), the Rights Assessment concluded the individual was unable to give informed consent in all six of the areas, but rarely offered any specific basis for this determination in the way of an individualized assessment of the individual's decision-making capacity. In some instances, the PST listed a comment for each of the categories, but the Monitoring Team found only one, for Individual #798, in which the PST attempted to tie the team's determination to a specific assessment process. In many of the others, the Monitoring Team found that essentially identical wording was used for the rationales offered for individuals when they had the same QMRP. The HRO had recently begun to provide training on guardianship and advocacy at New Employee Orientation. This included a role-play and a written test that focused on the importance of including the individual in decision-making even when there is an LAR. The Monitoring Team commends this initiative, which may positively impact the thoughtfulness of deliberations of the PST when they are considering the need for guardianship. The Monitoring Team continued to appreciate the Facility's commitment and devotion of staff time and resources to the promotion of self-advocacy, particularly as the development of self-advocacy skills can lead to enhanced decision-making skills and capacity. The Self-Advocacy group began meeting twice a month in April 2011, and some members also attended the community-based Fort Bend County Self Advocate meeting in Sugar Land, TX during the same month. The Monitoring Team reviewed the minutes of self-advocacy meetings that had been held over the past six months. While it was clear that individuals were encouraged to take an active part in the proceedings, there did not appear to be a consistent approach to teaching specific self-advocacy skills. It is recommended that the Facility evaluate options for using a formal decision-making curriculum as a part of its self-advocacy program.	

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		RSSLC had maintained a prioritized list of individuals who did not have a current guardian. The list was undated and included the names of 168 individuals. It was reported to have been updated in March 2011 to reflect changes related to recent community transitions, although it was noted the list included the names of three individuals who were also reported to have obtained guardians since 2010. This may have indicated a need to further update the list. The HRO indicated the prioritization process was unchanged from that in use during the last compliance visit. He reported a prioritization process was to be included in the expected statewide policy and that a local policy would be developed once this final statewide version was received. A review of the draft policy indicated a prioritization process was incorporated.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	This provision was found to be not in compliance. RSSLC reported that responsibility for this provision was vested with the HRO. The HRO reported he had taken on responsibility for guardianship issues, including tracking of expiring guardianships, assisting with documentation for guardianship applications and renewals and planning for successor guardianships. DADS draft Policy 019 specified that, as the Guardianship Coordinators, the HRO would play a significant role in the education of guardians, potential guardians and individuals who have either been identified as in need of an LAR or in the process of receiving an LAR. The draft policy called for the facility Guardianship Coordinator to: • Work closely with the facility Parent Association (if applicable) and provide information to the association members regarding local guardianship programs and resources at the facility Parent Association meetings. • Work with local guardianship programs, sharing appropriate information regarding individuals requesting an LAR, and soliciting information regarding community supports to assist with guardianship fees, court costs, etc. • Organize/host an Annual Guardianship In-service to individuals, families, facility staff, etc. to discuss guardianship needs, supports, and services. RSSLC reported some organized efforts undertaken to obtain LARs for individuals lacking LARs, or to provide education in the process, during this review period. The HRO stated he had met with the Facility Parent Association (Family and Friends) in March 2011 to discuss the process of developing the guardianship committee the new statewide policy draft would require. The Facility had also posted a notice on the entrance marquee to solicit interest in guardianship and advocacy. It was reported seven guardians had been obtained in the past six months, and one successor guardianship was in process for an individual who had previously been adjudicated as in need of an LAR. As part of the Facility undertaking an effective and	Noncompliance

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		appropriate large-scale effort to solicit guardians, the Facility should ensure it has an appropriate methodology in place to determine the actual need for guardianship and to educated potential guardians as described above. DADS should complete development of policy, including guidance on such a methodology, as soon as possible. Compliance with this provision will also necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a pre-requisite—that is, as required by this provision, that a prioritization of need exists, based on a reasonable process that includes established criteria, so that the Facility can identify people at highest need. While there would likely be instances in which the Facility would need to solicit an LAR for certain individuals, it should ensure it has an appropriate methodology in place to determine the actual need for guardianship before undertaking to recruit LARs on a large-scale basis. The Facility also reported it remained interested in developing an Advocate program. PSTs had been making referrals for advocates, but the Facility did not have such a program. In January, 2011, the Facility returned these referral forms to the QMRPs to complete addenda to let the PSTs know that the advocate program would need to be developed before referrals can be made. Although this step was noted to have been completed on the POI, a review of the 33 addenda provided to the Monitoring Team revealed that eleven (33%) were not completed by the individuals' PSTs. This also did not account for all 47 of the individuals named on the Advocate Referrals document dated 3/2/2011. There were no specific timeline or strategies in place for development of this program. The HRO indicated the Facility would likely begin to address this program after the statewide policy was finalized. It is recommended the Facility continue to pursue developing such a program as one alternative to guardianship.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. 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. DADS should ensure the pending statewide DADS Policy Number: 019 Guardianship and/or the pending policy on Rights Assessment will provide the PSTs with adequate guidance in this area. HRC members should receive some additional technical assistance in the rights review process, particularly as it relates to providing a more rigorous assessment of the information being provided to them by the PSTs.
2. The Facility should continue to provide Guardianship and Advocacy training during New Employee Orientation.
3. Once the statewide policies and assessment processes have been finalized, RSSLC should refine and develop facility-specific policies and procedures to operationalize the requirements. The Facility should ensure its policy and procedure, once developed, include:
   - 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.
   - The roles and responsibilities of the Facility in educating LARs and potential LARs in the roles and responsibilities of guardianship.

4. When soliciting an LAR for certain individuals, the Facility should ensure it has an appropriate methodology in place to determine the actual need for guardianship. DADS should complete development of policy, including guidance on such a methodology, as soon as possible.
5. The Facility should continue to pursue developing an Advocate program as one alternative to guardianship.

The following are offered as additional suggestions to the facility:
1. The PST for individual #641 should review the Rights Assessment again and re-consider the individual's capabilities.
2. The Facility should evaluate options for using a formal decision-making curriculum to bolster its self-advocacy program.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI) 4/18/11 2. RSSLC Settlement Agreement Status Update May 2011 3. DADS Policy 020 Recordkeeping Practices revised 3/5/10 4. RSSLC Policy A.6 Recordkeeping revised 3/29/11 5. RSSLC Policy F.5 Person Directed Planning and Active Treatment: Completing Personal Support Plan Documentation revised 10/24/10 6. RSSLC Active Record Order & Guidelines (AROG) revised 8/26/10 7. Master Record Index/Table of Contents undated 8. Chart 1/Group Notebook Audit form and audits for Individuals #503 and #596 9. List of where documents can be found--undated 10. Chart breakdown for individuals with two charts, three charts, or four charts 11. Filing for Active Record table showing responsibilities for filing specific documents, undated 12. Description of quality assurance procedures titled Section V. Recordkeeping, dated 3/20/2011 13. Blank copy of form titled Settlement Agreement Provision V.4—Interview Tool for the use of the Record, and guidelines for completion 14. New Employee Training power point and test for Recordkeeping, and sign-in sheet for 4/1/11 training 15. Outline, test, and sign-in sheet for New Hire Nurses Training on Recordkeeping of 4/25/11 16. Outline, test, and sign-in sheet for Infirmary Nurse training on Recordkeeping/AROG of 4/26/11 17. RSSLC Active Record Review and Settlement Agreement Cross-Referenced with ICF-MR Standards audit forms completed for Individuals #503 and #596 18. Active Record and Master Record for Individual #573 19. Active Record and Group Notebook for Individuals #503 and #596 20. PSP Discipline's Assessments Tracking Worksheet for Individuals #96, #137, #268, and #384 21. Assessment Tracking by Discipline data for 1/1/11-5/5/11 22. Bar graphs by month of AssessmentTracking by Discipline 1/1/11-5/5/11 23. POI Database Manual developed by RSSLC and El Paso SSLC, undated 24. Section V Monitoring Tool Random Sample lists by unit for March, 2011 25. Reports from the RSSLC monitoring database including: 26. Audits completed by departments (date, name auditor, score) 5/1/10-4/18/11 (with data only for March and April, 2011) 27. Bar graph of Record Keeping and General Plan Implementation Level of Compliance—Department Audits for 3/11 and 4/11 28. Table—Level of Compliance with item by item aggregate data for 3/11 and 4/11 29. Table—Level of Agreed Compliance between QA and Department Auditors on Y/A/NA Answers for 3/11 and 4/11 30. Table—Level of Agreed Compliance between QA and Department Auditors on Y Answers for 3/11 and

	4/11 31. Table—Compliance Scores by Auditors for 3/11 and 4/11 **People Interviewed:** 1. Wanda Hartensteiner, Director of Medical Records, and Susan Steamer and Tracy Stafford, Unified Records Coordinators 5/2/11 2. Alice Ramirez, Data Analyst, and Joan Poenitsch, Director of QA, 5/3/11 3. Andrea Faniel, Program Monitor 5/3/11 4. Tran Quan, M.D., Medical Director, three speech and language pathologists, seven nurses, and one QMRP regarding use of records 5. DCP and Home Supervisor at Neches B **Meetings Attended/Observations:** 1. Active Treatment Meeting, 5/3/11 2. PSP Annual Planning Meeting for Individual #96 3. Medical Staff meeting with community hospital 5/3/11 4. At Risk Team Meetings for Individuals #363 and #385
	Facility Self-Assessment: The Facility reported that it was not in compliance with any provision of this Section. The Facility reported it had taken several actions to help achieve compliance. The Facility reported the Unified Records Coordinators began training new staff during new employee orientation and new nurses during their new nurse orientation. They gave a competency-based test at the end of each session and a return demonstration to evaluate competency at the end of new nurse orientation training. The Facility reported that Unit Clerks have started reviewing a sample of records on their respective units each month. The Unified Records Coordinators then review a sample of those records to validate the findings of the Clerks' reviews. During the visit, the Monitoring Team was also apprised of the availability of a database that can provide information about the findings of the reviews as well as about the inter-rater reliability found in the validation audits. The Facility reported that corrective action plans have not yet been initiated. The Monitoring Team concurred with the self-assessment provided by the Facility.
	Summary of Monitor's Assessment: The Facility maintained a Unified Record for each individual. The Unified Record at RSSLC consisted of an Active Record, Master Record, and an individual section in a Group Notebook. Active Records were filed in two, three, or (in a few cases) four charts, depending on the amount of documents involved. A Record Order & Guidelines listed the order of documents and the maintenance guidelines that stated how long each document should remain in the Active Record; this was filed in the front of every chart. Policy for recordkeeping at the Facility was specified in policy A.6 Recordkeeping, which was revised 3/29/11. This policy was consistent with DADS recordkeeping policy and with Appendix D of the SA. In

	addition, the facility policy contained additional information and notes to operationalize the policy. Review of records for a sample of individuals showed that they approached compliance with Facility expectations and Appendix D of the SA. Although records were generally in order and, for the most part, complete and legible, none of the records met all the requirements. Nevertheless, the records showed improvement over time since the baseline visit. Records could be found and provided quickly, and staff could show where documents for individuals were in the group notebooks. Although not considered by the Facility to be part of the Unified Record, the Share drive provided the potential for accessibility to assessments by all members of the PST. Unfortunately, filing of assessments was not consistently done prior to the PSP meeting, so this system was not yet fully useable. The Facility had initiated training new staff during new employee orientation and new nurses during their new nurse orientation. The training for new employees provided a good description of the rules for recordkeeping found in Appendix D of the SA as well as a description of the AROG and checkout procedures. True-False questions were used to test for competence; there was not a formal process to test for correct documentation practices. There was additional training provided to newly-hired nurses. This training was reported to include demonstration of skills; the information provided to the Monitoring Team did not describe the skills to be demonstrated. Although the Facility might address revisions in testing competence, this training is an important improvement. RSSLC had initiated a robust record audit process that includes audits by Unit Clerks, with the Unified Records Coordinators reviewing a sample of those done by the Unit Clerks to determine inter-rater agreement. A second audit process also existed in which Program Monitors reviewed the share drive to determine whether assessment reports had been posted and also, following the annual PSP planning meeting, checked the group notebook for the presence of SPO and SSO data sheets. These two complementary processes provided considerable information that was entered into a database that provided reports on compliance with requirements. The database could provide a vast array of information. It would be advisable for the Facility to coordinate these two audit processes. The Monitoring Team independently reviewed a sample of Active Records and found a reasonably acceptable level of agreement with the reviews done by Facility staff (given that this review was done at a different time, and corrections and other changes in the records might have occurred during the interim); at the same time, there were issues of concern with items rated as NA (not applicable) that, based on other findings in the record, should have been considered applicable and missing. This audit process itself, although implemented and revised recently, could be considered to meet the auditing requirements of this provision. However, the process for requiring corrections for errors in the record was informal. As reported by the Director of Medical Records and the Unified Records Coordinators, requests for correction were mostly made verbally to the person who needed to make the correction or to a supervisor. There was not yet a process to follow up to ensure corrections were made. A process to assess use of records in making decisions about treatment, services, and interventions was

	planned but not yet implemented. Using a similar process and instrument, the Monitoring Team gathered information that confirmed, for a sample of clinicians, that documentation could usually be found and that staff perceived they used information from other disciplines in making decisions. Nevertheless, as reported in several sections of this report, there were instances in which staff did not use or could not find information in the record but instead made decisions based on anecdotal information; furthermore, problems identified in Section F indicate that data that were available were not necessarily accurate and useful. The State and Facility had developed or revised numerous policies. This process is continuing. Many of the policies were recently implemented, and implementation was not yet complete or entirely accurate. The Facility had not developed processes for the dissemination of policies and training of staff on new or revised policy requirements. Although the Monitoring Team noted many improvements in practices, it concurs with the Facility's report that it is not yet in compliance with any provision of this section.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	The Facility maintained a Unified Record for each individual. The Unified Record at RSSLC consisted of an Active Record, Master Record, and an individual section in a Group Notebook. When documents are purged from the Active Record, they are to be put into a manila folder and sent to Medical Records to retain as overflow. In addition, assessments and some other information were copied to a shared drive that was not considered part of the unified record but allowed information to be easily accessible to members of the PST. Policy for recordkeeping at the Facility was specified in policy A.6 Recordkeeping, which was revised 3/29/11. This policy was consistent with DADS recordkeeping policy and with Appendix D of the SA. In addition, the facility policy contained additional information and notes to operationalize the policy (for example, to identify the specific offices or staff responsible for certain actions and to add requirements such as chart check-out procedures). The policy included an attachment that described disciplinary actions for falsification of records; this attachment included illustrative examples of prohibited practices. The Monitoring Team would recommend reconsideration of one instruction in the policy. Step 4 of the section headed Accessibility of Records included a note describing what to do with the record when an individual dies on campus. The policy instructed that the record "should remain on the home until the next working day to allow for necessary record review and documentation" and should then be brought the next day to Medical Records. The record may serve as evidence during the review of the death and should	Noncompliance

		not be altered following death. The Monitoring Team recommends that the Facility consider revising this process so the record is immediately protected as evidence, including storage in the evidence room or locker, and checked out as needed only by approved staff. Additional information can be documented separately and added to the record after the clinical and administrative review is done and the investigator releases the record following review for the investigation. Active Records were filed in two, three, or (in a few cases) four charts, depending on the amount of documents involved. A Record Order & Guidelines listed the order of documents and the maintenance guidelines that stated how long each document should remain in the Active Record; this was filed in the front of every chart. A separate document provided a chart breakdown that stated in which chart documents would be filed if there were two, three, or four charts. In addition, this breakdown was listed at the top of the first page of the Active Record Order & Guidelines. Policy A.6 included an instruction to Unit Clerks to label each chart by volume (e.g., Chart 1 of 2, Chart 3 of 3); all records reviewed by the Monitoring Team were labeled in this way. When more than two charts were used for a record, medical and health information were spread across charts. For example, when three charts were used, the chart breakdown instructed that sections on Health Data, Hospital, Health Status, and others would be in Chart #2 but Physicians Orders and Integrated Progress Notes (IPN) would be in Chart #3. The Monitoring Team did not determine whether this caused difficulty or added time to access information. Given the extensive documentation that may be in records, it might be difficult to resolve this so all necessary information is easily accessible. 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 for Individuals #503, #573, and #596, as well as the Master Record for Individual #573 and the Group Notebook for Individuals #503 and #596. Although records were generally in order and, for the most part, complete and legible, none of the records met all the requirements. For the Active Record, the Monitoring Team checked for the presence of each item on the Active Record Order & Guidelines. Many documents are not applicable in each record. The Monitoring Team made an effort through review of other documents in the record to determine whether such a document, if not in the record, was applicable. For example, if an individual had in the record an action plan with a specific learning goal, there would be an expectation that a matching Specific Program Objective would be in the appropriate section of the record. For two of three individuals (67%), greater than 90% of documents were found in the record; the third individual had been admitted recently, and the percent of documents in the record was lower. • For the Active Record for Individual #503, 81 of 87 (93%) required or applicable	

		documents were found in the record. • For the Active Record for Individual #573, 43 of 56 (77%) required or applicable documents were found in the record. This individual had been admitted in December 2010, so there were a greater number of documents that were not yet due and were therefore considered not applicable (such as quarterly PSP reviews). • For the Active Record for Individual #596, 71 of 75 (96%)required or applicable documents were found in the record. In addition to reviewing the Active Record against the Active Record Order & Guidelines, the Monitoring Team assessed the Active Record for each of the above individuals for compliance with the requirements of Appendix D of the SA. • For Individual #503 o The Active Record and Group Notebook were checked. o All required documents were found in the Group Notebook. o In the Active Record, there was no HRC referral form although the individual had a safety plan using protective restraint. Also, there was no Structural and Functional Assessment Report in the Behavioral Services tab; the Monitoring Team did not check to determine whether this essential assessment had been done. o There was no Physicians Approval and Review of Proposed Restraint in Behavioral Services section. o There were no PSP Reviews in the chart. o Psychoactive Medication Review Quarterlies were not found in the Psychiatry section. o PSP addendums were not filed in chronological order. o Documents were generally legible. • For Individual #573 o The Active Record and Master Record were checked. o All required documents in the Master Record were present and in the correct order. o In the Active Record, Special Program Objectives (SPOs) and Special Service Objectives (SSOs) were missing from the Progress Notes section. That meant that data for the month were not being recorded in the chart. Furthermore, the Active Medical Problem List was not in the Health Data section. o Numerous observation notes were not legible. o The PSP Reviews section contained progress notes for a different individual. o Although the AROG specified reverse chronological order, the observation notes were in regular chronological order.	

		o The MAR from December 2010 remained in the chart when it should have been sent to Overflow. o There were numerous instances of no initials on error scratch-through in physician orders. • For Individual #596 o The Active Record and Group Book were checked. o In the Group Book, the Communication Dictionary was missing; data were missing for two of three SPOs (67%); the PNMP, PBSP, and Schedule were present in the correct location. o In the Active Record, the PSP Review for January-March 2011 was missing. o There was no Structural and Functional Assessment Report in the Behavioral Services tab to support the PBSP. o The Behavioral Assessment was filed out of order in front of rather than behind the PBSP. o A Functional Assessment Update in the Behavioral Services tab was not the Structural and Functional Assessment Report that should go into that tab but was a functional skills assessment that should have been filed in the Functional Skills Assessment tab. o There was no "Pre-Sedation Assessment" in the Restraints Checklists section. o One observation note was misfiled to another section, and several observation notes were torn out and required reinforcers. o Consent for a psychotropic medication was missing. o There were numerous gaps at the bottoms of pages. o Documents were generally legible. When asked, direct care staff immediately directed the Monitoring Team to the correct locations in the Group Notebook where documents could be located. Many nursing progress notes and signatures and titles continued to be illegible. Although not considered by the Facility to be part of the Unified Record, the Share drive provided the potential for accessibility to assessments by all members of the PST. Policy F.5 on PSP documentation requires PST members to file their assessments and recommendations on the Share drive 10 days prior to the PSP meeting. As reported in Provision V3, filing of assessments was not consistently done prior to the PSP meeting, so this system was not yet fully useable. The Facility had initiated training new staff during new employee orientation and new nurses during their new nurse orientation. The Monitoring Team reviewed the content of these training sessions and the tests at the end of the sessions. The training for new	

		employees provided a good description of the rules for recordkeeping found in Appendix D of the SA as well as a description of the AROG and checkout procedures. The True-False test covered a limited portion of the contents of the training. According to the Director of Medical Records, training on actual documentation is done by residential supervisors through on-the-job training. The Monitoring Team recommends that the Facility develop a system to monitor the documentation done by new employees after on-the-job training, perhaps through checks by the Unit Clerks or Unified Records Coordinators. In addition to the new employee training, newly hired nurses received a further 90-minute training a few weeks later. During this period, experienced nurses provided on-the-job training. The follow-up training provided by the Unified Records Coordinators included review of the policy and AROG but also involved the use of a mock record. In this training, nurses showed where documents should be placed in the chart and reviewed a variety of reports. The training outline included "Return demonstration of information reviewed" but did not indicate which information or what the demonstration covered. A different and more detailed multiple-choice and true-false test was given. Although this was introductory training about recordkeeping and not about how to carry out assessments and write documentation, it would be easy to convert much of the test to a competency-based test about the information covered; instead of answering questions about how to do tasks, the test could include scenarios and require that the nurses carry out the tasks correctly without the prompts that multiple-choice and true-false questions provide.	
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.	As discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. This included policies that DADS State Office was developing, as well as those being developed or revised at the Facility level. DADS continued to develop and revise policies. DADS provided a listing of policies in development and revision that included implementation dates. Review of policies during this visit found the listing to be accurate. Several policies remain in development or were recently implemented. For example, the policy on Physical and Nutritional Management was implemented 3/21/11. Some policy development or revision is waiting for final approval of statewide DADS policies. For example, as reported in Provision U1, prioritization of need for guardianship is awaiting approval of the DADS Guardianship policy. In its document request, the Monitoring Team asked for a list of each new or revised policy since the last review, and "a copy of communication to staff to inform them of the policy, a description of training provided (with a copy of training materials), and/or blank competency evaluation tools." In response, the Facility sent a list of policies that	Noncompliance

		were new or revised since the last compliance visit and copies of emails that had been sent by the SAC informing specific individuals of the changes in policies. The Facility had reviewed numerous policies since this process began. According to the list of new or revised policies, 44 policies were approved since the last compliance visit. The list does not indicate which policies were newly developed and which were revised. Many of the new and revised policies specifically related to provisions of the SA. The Monitoring Team reviewed a number of policies that were necessary to implement Part II of the SA. This list indicates the Facility was actively developing and revising policies to meet the requirements of this provision, although not all necessary policies were yet in place. Descriptions of those may be found in relevant sections of this report. These included the following policies: • RSSLC Policy J.1: Use of Restraint 3/1/11 and other policies related to restraint (J.2, J.4, and J.5) • RSSLC Policy C.1 Reporting Abuse, Neglect, Exploitation 2/24/11 and other policies related to such reporting (C.2 and C.3) • RSSLC Policy E.17 Completing Incident Information Reports 2/28/11 • RSSLC Policy F.4 Support Plan Process (Integrated Protections, Services, Treatments, and Supports)12/30/10 and other policies related to the PSP (F.1, F.2, F.3, F.5, and F.6), and RSSLC Policy F.18 Participating in Personal Focus Assessment Meetings 4/20/11 • RSSLC Policy: Nursing Services, I.00b, Effective: 4/1/11 • RSSLC Policy Physical and Nutritional Management (Policy #012.2 dated 3/21/2011 • RSSLC Policy J.6 Psychological and Behavioral Services • RSSLC policy K.6 Communication Services 1/31/11 • RSSLC Policy A.6 Recordkeeping 3/29/11 Reviews of these policies and of how they were being implemented can be found in relevant sections of this report. Many of the policies were recently implemented, and implementation was not yet complete or entirely accurate. One problem might be the format in which several policies related to one issue, so staff had to review a number of different policies to ensure they understood and followed all required procedures. Section D of this report provides further explanation of how this affected accuracy of implementation of policies and procedures related to incident management. Emails did not include any description of training. No training materials were provided to the Monitoring Team. Most emails provided a link to the share drive where the policy could be accessed. No documentation was provided of notice to staff other than those who received the emails, although one asked the Director of Medical Services if she would let the doctors know, and one stated that the SAC had been informed training	

		would be provided to home supervisors and program area supervisors. This is inadequate to ensure that appropriate notification is provided to all staff and that competency-based training is provided when procedures are changed. The Facility should establish a process to provide to all staff and document they have received information about new and revised policies, including determining which require competency-based training and how competency will be determined and documented. It was positive to find since the last compliance review that the Nursing Department had developed and implemented a new policy for documenting nursing staffing coverage on 4/1/11. It was positive to find since the last compliance review that the Pharmacy had developed and implemented a Medication Errors/Variances Policy that included errors/variances resulting from dispensing, distribution, erroneous data entry on profiles, missed allergies, administration, prescribing, order communication, storage, product labeling, packing, nomenclature, compounding, education, and monitoring.	
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.	RSSLC had initiated a robust record audit process. Audits by Unified Records Coordinators had begun in October, 2010. Beginning in March, 2011, the process was expanded to include audits by Unit Clerks, with the Unified Records Coordinators reviewing a sample of those done by the Unit Clerks to determine inter-rater agreement A second audit process also existed in which Program Monitors reviewed the share drive to determine whether assessment reports had been posted and also, following the annual PSP planning meeting, checked the group notebook for the presence of SPO and SSO data sheets. These two complementary processes provided considerable information that was entered into a database that provided reports on compliance with requirements. The Active Record audit process, as described in Section V Recordkeeping and in interview with the Director of Medical Records and Unified Records Coordinators, begins with random computer identification of five records to audit for each of the six residential units. The Unified Records Coordinators send an email on the last working day of each month to each Unit Clerk with the list of records to review. Unit Clerks review records from their own units and enter the results into the database. The Unified Records Coordinators select the third from each list and, for a rotation of the units, also the fifth name to provide a total of 10 records to review for validity (the Facility was in process of closing one unit—when that is done, the third and fifth names will be selected for each unit). The Monitoring Team was informed that Unit Clerks reviewed two records each in March and five in April. The Audits Completed by Departments report confirmed 12 audits in March and identified 29 audits in April. This number far exceeded the requirement of the SA to review at least five records each month.	Noncompliance

Reviews were performed using two forms. The Active Record Review listed all the documents on the AROG and had columns to report whether they were each present, absent, or not applicable; it also had a column for comments that provided a place to note problems with documents, such as filing out of order. The Settlement Agreement Cross-Referenced with ICF-MR Standards audit form listed requirements of Appendix D of the SA and had columns to record Y, N, or NA and comments including specific reasons for rating N. Scores for the items on this form were entered on the database and aggregated for reports.

Levels of compliance varied widely across items. The table on Level of Compliance based on Departmental Audits reported 11% compliance for "No gaps between entries" for April, 2011 and 100% for having a table of contents. Monthly average compliance across all items for March 2011 was 76% and for April 2011 was 74%.

Levels of agreement between Unit Clerk (Department) audits and Unified Records Coordinator (QA) audits also showed a wide range across items, from 0% for "The record consistent (sic) with this table of contests (sic)" to 100% for "This record has a table of contents(.)" Overall agreement was reported to be 57.14% for March 2011 and 59.29% for April 2011. It will be important for the Facility to identify items on which agreement is low and develop definitions and criteria for ratings.

The Monitoring Team compared data on presence of documents listed on the AROG with data from the RSSLC Active Record Review (which listed the same items plus a few items that are specific to RSSLC records) and the evaluations on a checklist of Appendix D requirements to the same items on the Settlement Agreement Cross Referenced with ICF-MR Standards for Individuals #503 and #596. Because there was a time period in between the Facility review and the Monitoring Team review, there could be an expectation of reduced agreement if documents had been added or purged in the interim.

- Individual #503 (Facility review 3/22/11)
    - For documents on the AROG, there was agreement on 75 items in which both reviewers found the document present and two items in which both found the document absent, and there was disagreement on only two items, for a percent of agreement of 97%. For items marked NA by one or the other reviewer, there was agreement on 36 items and disagreement (that is, one reviewer found the item NA whereas the other marked it present or absent) on 14 for a percent of agreement of 72%. A troubling finding was that four of the items of disagreement involved findings by the Facility relevant to the use of behavioral procedures, psychoactive medication, and protective restraint. Although the individual had a PBSP, was prescribed psychoactive medication, and had a safety plan for protective restraint, the Facility

		marked the following documents as NA: HRC Referral Form, Structural/Functional Assessment, Physician's Approval and Review of Proposed Restraint, and Psychoactive Medication Review Quarterly. To summarize, there was a high degree of agreement on presence or absence of documents, a lower degree of agreement on whether documents were applicable, and a few documents for which parts of the record showed them to be applicable but they were absent and found NA by the Facility. o For the checklist items reviewed by both the Facility and the Monitoring Team (a subset of the items reviewed by the Facility itself), there were agreements on six items and disagreements on two, for a percent of agreement of 75%; at least one item (chronological order) might have been corrected in between the reviews. • Individual #596 (Facility Review o For documents on the AROG, there was agreement on 68 items in which both reviewers found the document present and one item in which both found the document absent, and there was disagreement on only three items, for a percent of agreement of 96% (even though one item of disagreement, absence of PSP review for the months of January-March, 2011, would not have been due at the time of the Facility review). For items marked NA by one or the other reviewer, there was agreement on 47 items and disagreement (that is, one reviewer found the item NA whereas the other marked it present or absent) on 15 for a percent of agreement of 76%. There was a high degree of agreement on presence or absence of documents, a lower degree of agreement on whether documents were applicable, and a few documents for which parts of the record showed them to be applicable but they were absent and found NA by the Facility. o For the checklist items reviewed by both the Facility and the Monitoring Team, there were agreements on five items and disagreements on four, for a percent of agreement of 55%, approximately the same as reported by the Facility for agreement between Department and QA auditors. For three of the disagreements, the Facility found the record did not meet the standard, so the Facility was being, to its credit, being critical in its ratings and requiring a high standard. Reports were provided by the QA Department in both table and bar graph formats. Both are useful. Tables can provide itemized detail that can be used to identify specific issues needing to be addressed. Graphs provide a visual reference of progress. The bar graphs had different ordinates, so comparisons among items were difficult to make without referring to the actual percentages. The Facility should consider revising the database reporting so all bar graphs presenting percentage data had ordinate scales from 0-100%.	

		The audit process itself, although implemented and revised recently, could be considered to meet the auditing requirements of this provision. However, the process for requiring corrections for errors in the record were informal. As reported by the Director of Medical Records and the Unified Records Coordinators, requests for correction were mostly made verbally to the person who needed to make the correction or to a supervisor. There was not yet a process to follow up to ensure corrections were made. To achieve compliance, a process to assign corrections, be informed when corrections have been made, and verify at least a sample of the corrections must be in place and effective. Furthermore, although the database provided a great deal of information, the new audit system had been in place for less than two full months; therefore, there had not yet been a chance to look for trends in the findings and develop corrective systemic actions. One action had been taken. Based on information from the audits, a training session was held for nurses in the Infirmary on 4/26/11 to cover concerns over documentation done during Infirmary stays and improve consistency in following the requirements of Appendix D. The other process for audits involved reviews by the Program Monitors. One issue reviewed was whether assessments were posted to the share drive 10 days prior to the annual PSP meeting, and presence or absence is documented on the Discipline Tracking Worksheet. By report of a Program Monitor, the share drive is checked 10 working days prior to the scheduled PSP meeting. The Program Monitors send all Discipline Tracking Worksheets to the Director of Residential Service. This information is also entered into the database. The Program Monitors also check the Group Notebook 11 days following a PSP planning meeting to check whether data sheets for SPOs and SSOs have been put in; findings are sent to the Director of Education, Unit Director, Director of Residential Services, and Assistant Director of Programs. The Program Monitors additionally each pick one group from each house (that is, the individuals whose information would be in one group book) and complete the Group Notebook audit form. Each audit is sent to the Unit Director and Director of Residential Services. No trend information had been provided to the Program Monitors or was provided to the Monitoring Team. The Monitoring Team reviewed the following: • PSP Discipline's Assessments Tracking Worksheet for Individuals #96, #137, #268, and #384 • Assessment Tracking by Discipline data for 1/1/11-5/5/11 • Bar graphs by month of assessments tracking by discipline 1/1/11-5/5/11	

Information from the Assessment Tracking Worksheets indicated assessments to not always get posted to the share drive timely and therefore are not easily accessible to other PST members for review prior to the PST annual meeting.

Individual #	Number of required assessments in share drive 10 days before PSP/not in timely	Number of assessments QMRP provided notice to UD	# of assessments information was/was not obtained for PSP
#96	10/5 (67%)	5 (100%)	2/3 (40%)
#137	11/4 (73%)	4 (100%)	2/2 (50%)
#268	8/6 (57%)	No info	No info
#384	4/10 (40%)	10 (100%)	No info

The Facility had initiated a robust and thorough audit system for active records that included checks of inter-rater agreement. Trending of information was not yet reviewed and used to identify corrective or improvement actions. The process for correction of errors discovered during audits was informal and did not include a structured process to ensure corrections were made. The audit system for posting assessments to the share drive and for checking whether data sheets were put into the Group Notebooks was robust and did include notice to administrative and supervisory staff but also did not include a process to ensure corrections were made.

These two processes were carried out by different staff; although they were all part of the QA department, the two processes were not integrated. Staff carrying out one of these processes did not know what is audited by the other audit processes, there was no intentional overlap of items checked, and there was no sharing of data to provide information on trends..These processes provide a valuable opportunity to identify trends, to ensure that different auditors reviewing the same records agree on presence or absence of documents and on quality of documentation (when that is part of an audit), and to provide information that helps improve documentation and recordkeeping. The Facility should coordinate these two processes in order to facilitate decision-making on improvement initiatives and to develop a unified corrective action system.

V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	In responding to the concern at the last compliance visit about accessibility of records to staff who need them and ability to find them, the Facility developed a check-out system for accountability. There were no problems finding and providing records during this visit. For two of two individuals checked (100%), group notebooks were available. Within each group notebook, there was a section for each individual that included the PSP, PBSP	Noncompliance

		(if any), PNMP, and program objectives with data sheets for the current month. For one of two individuals (50%), all data sheets were available and being completed. The Facility planned to begin in May to interview staff to determine use of the records in making care, medical treatment, and training decisions, and to document the information from interviews on a form titled Settlement Agreement Provision V.4—Interview Tool for the use of the Record. The Facility provided to the Monitoring Team a blank form and a set of interview guidelines. The guidelines require Unified Records Coordinators to complete one interview per month of one staff member from each of seven disciplines and quarterly for three other disciplines. The guidelines appropriately call for the interview tool to be used for "teaching opportunities to help people learn how to use the information in the record to make decisions based on integrated planning and critical thinking"; although this is a good plan that may provide some guidance on general use of the records, the Unified Records Coordinators do not have the clinical backgrounds to provide all the guidance that would be helpful. Therefore, as this process develops, the Facility might wish to consider providing other opportunities for clinicians to share information on how they use the records. The Monitoring Team interviewed a sample of nurses and SLPs and one QMRP and the Director of Medical Services, using a similar interview tool that included many of the same questions. Nurses were given the tool and wrote their responses. Ten of 13 (77%) interviews reported staff could or usually could find the documents they needed; three of 13 reported that the individual could not find documents in the record or that some documents were hard to find. Eleven of 13 (85%) interviews provided examples in which a report from another discipline helped in planning a treatment or intervention; most of those examples were general comments about information that may be used (such as looking at weight versus desired weight range when discussion MBSS, or looking at other discipline records to see if someone is making progress); four of the 11 interviews that provided examples (36%) provided a specific example of an individual case (unidentified but with enough detail to state how the information was helpful). The Monitoring Team will prompt interviewees to provide specifics in future interviews. Interviews provided suggestions for making the Active Record more useable. These included two comments that indicate unfamiliarity with Facility policy: • One interview suggested there should be a sign-in sheet to trace the record when in use by another discipline. The Monitoring Team notes that this is required by the Facility recordkeeping policy A.6. • One interview noted the record goes with an individual who goes to the hospital but information from the record might be needed before the individual returns. The Monitoring Team notes that policy A.6 requires that the record be taken to Medical Records, not sent to the hospital.	

		Other suggestions included: • Change to computer charting and computerization of records. • One suggestion was to have fewer binders, but another suggestion was to separate chart 3 because it is overflowing. • Move the active problem list to chart 3. • Have more subtabs to make access quicker. There are a number of examples found throughout this report that document lack of use of information in the record, including the following: • Provision C5 identifies examples in which medical and dental plans had been developed for individuals but were not implemented as planned. • Provision C8 points out that PST members participating in review of restraint at the IMRT did not have documents and data to review, and that review at the IMRT was based primarily on anecdotal information and the account presented by the Unit Director or psychologist. • Problems with data collection and display identified in Provision F2a6 limited the ability to determine whether a PBSP or psychotropic medication was providing any benefit to individuals, as described in Provision F2d. • An example was provided in Provision I1 of an instance in which staff reported information on falls during a PSP annual planning meeting that did not match data on falls in the record, and documentation of a reported event could not be found in the record. Although the Facility was planning to begin a process to evaluate use of the records in making decisions, the process had not yet been implemented. Development of a checkout system and the ability of staff to locate specific records were positive findings. Nevertheless, there were numerous examples that demonstrated that use of the records in making decisions, while perceived to be routine, was not consistent. • As reported in Provision H3, interventions were not always revised when there was lack of effectiveness or change in health status. • Assessments were not always documented timely, as evidenced by the number of assessments that were not placed on the share drive so they would be available for review by PST members prior to an individual's annual PSP planning meeting. Therefore, this provision has not yet reached compliance.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Establish a process to provide to all staff, and to document they have received, information about new and revised policies, including determining which require competency-based training and how competency will be determined and documented.
2. Consider revising the process for securing records following a death so the record is immediately protected as evidence.
3. Consider revising the database reporting so all bar graphs presenting percentage data had ordinate scales from 0-100%.
4. Consider coordinating thetwo separate audit processes in order to facilitate decision-making on improvement initiatives and to develop a unified corrective action system.
5. Identify audit items on which agreement between Unit Clerks and Unified Records Coordinators is low and develop definitions and criteria for ratings.
6. Develop a system to monitor the documentation done by new employees after on-the-job training, perhaps through checks by the Unit Clerks or Unified Records Coordinators

List of Acronyms Used in This Report

Richmond SSLC
May 1-6, 2011 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
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
AROG	Active Record Order & Guidelines
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
IED	Intermittent Explosive Disorder
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 Staphylococcus Aureus
NA	Not Applicable

NCP	Nursing Care Plan
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NP	Nurse Practitioner
OCD	Obsessive Compulsive Disorder
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
PBMC	Psychiatric and Behavior Management Clinic
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
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
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 (and Evaluation) 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
US	Ultrasound
VCF	Virtual Client Folder
VDB	Verbally Disruptive Behavior
VNS	Vagal Nerve Stimulator
VRE	Vancomycin-resistant enterococcus
x/o	Rule out